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The Louisiana State University and Agricultural and Mechanical College, Ph.D., 1971
Sociology, general

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The Occupational Role of the Public Health Administrator in New Jersey

A Dissertation

Submitted to the Graduate Faculty of the
Louisiana State University and
Agricultural and Mechanical College
in partial fulfillment of the
requirements for the degree of
Doctor of Philosophy

in

The Department of Sociology

by
Mark Anthony Quinones
B.A., Southeastern Louisiana University, 1955
M.A., Louisiana State University, 1955
M.H.A., Wayne State University, 1956
December, 1971

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The completion of this study comes at a crucial point in this writers' academic and professional life, and I would be remiss if I failed to acknowledge the "significant others" who through the years contributed so much to its realization. At the outset, I must express my appreciation and gratitude to Professor George S. Tracy, Department of Sociology, Louisiana State University for a number of reasons. First, it was he with whom I initially discussed the possibility of this study -- and out of this discussion evolved the theoretical framework. Secondly, throughout the study, he served as its major critic, constantly refocusing toward the prime objectives of the study. And thirdly, I am grateful to him for his willingness to step into the chairmanship of my doctoral committee, at a time when we were all deeply saddened by the passing of Dr. Walfrid J. Jokinen, Chairman, Department of Sociology.

As a fellow student in the early years of my graduate work at Louisiana State University, and later in his capacity as initial chairman of my doctoral committee Dr. Jokinen was always an inspiration. All of us who were associated with him will miss him immensely.

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TO THE LADIES IN MY LIFE:

MY MOTHER,

MY WIFE,

MY DAUGHTERS

WHO THROUGH THEIR ENCOURAGEMENT, PATIENCE, AND TOLERANCE HAVE IN THE FINAL ANALYSIS EMERGED AS THE "REAL PROFESSIONALS"

TABLE OF CONTENTS

		Page
Acknowledgements		ii
List of Tables		viii
Abstract		xiii
Chapter:		
I:	Introduction	1
	A. Purpose of the Study	1
	B. The Problem	1
	C. Significance of the Study	3
	D. Suggested Hypotheses	5
	E. The Data	6
II:	Theoretical Frame of Reference	10
	A. The Approach	10
	B. Theoretical Aspects	12
	C. Definitions of Major Terms	14
	D. Role Theory	19
III:	Sociology of Work	30
	A. The General Conception of Work	30
	B. The Professions	34
IV.	Public Health Administration	53
	A. Brief History of Public Health in New Jersey	53
	B. The Public Health Administration Today	63
V.	Data and Analysis of the Occupation	66
	A. General Characteristics	66
	B. Work Experience	76
	C. Recruitment	87
	D. Training	90
	E. Community Setting	101
	F. Membership	105
	G. Job Satisfaction	118
	H. Career Satisfaction	136

Page

VI: Summary..... 150

Selected Bibliography..... 174

Appendices..... 178

Vitae 206

LIST OF TABLES

TABLE		Page
Table 1:	Respondents Classified by Occupational Status and Extent of Service Area.....	67
Table 2:	Respondents Classified by Occupational Status, Location of Residence, and Service Area.....	67
Table 3:	Respondents' Reasons Why Health Administrators Should Live in Community Served.....	68
Table 4:	Respondents' Reasons Why Health Administrators Should Not Live In Community Served.....	69
Table 5:	Health Administrators Response to Ownership of Residence.....	70
Table 6:	Health Administrators Response To Location of Business Headquarters	70
Table 7:	Age Distribution of Respondents.....	71
Table 8:	Annual Income of Respondents.....	72
Table 9:	Number of Health Administrators Holding Professional Licenses By The Type of License and Period First Obtained.....	73
Table 10:	Educational Achievement of Respondents	74
Table 11:	Frequency of Specialized Training According to Type of Institution and Area of Training For Health Administrators.	75
Table 12:	Frequency According to Years Since Specialized Training Obtained By Type of Institution for Health Administrators	76
Table 13:	Years Health Administrators Employed in Public Health.....	77

Table		Page
Table 14:	Years Health Administrators Have Been Employed in Present Position	78
Table 15:	Public Health Positions Previously Held By Health Administrators By Length of Service	79
Table 16:	Status of Present Position of Health Administrators	79
Table 17:	Other Positions Currently Held By Health Administrators By Length of Time and Type of Position	80
Table 18:	Comparative Importance of Multiple Positions of Health Administrators	81
Table 19:	Reasons Why Present Position Is Important To Health Administrators.....	82
Table 20:	Position or Relationship With Teaching Institution as Reported By Health Administrators	83
Table 21:	Academic Rank of Health Officers	83
Table 22:	Institution Where Academic Rank is Held By Health Administrators	84
Table 23:	Duties of Health Administrator At Academic Institution	84
Table 24:	Type of Professional Papers Read and/or Published by Health Administrators	85
Table 25:	When Paper Was Read and/or Published By Health Administrator	85
Table 26:	Where Paper Was Read and/or Published By Health Administrator	86
Table 27:	Audience Composition For Papers Read and/or Published By Health Administrators	87
Table 28:	Sources of Interest in Public Health Work As Reported by Health Administrators	88

Table		Page
Table 29:	Reasons For Deciding To Become A Health Administrator	89
Table 30:	Other Factors Influencing Decision To Be A Health Administrator	90
Table 31:	Response of Health Administrators To Question, Was There Any Training Required for Position?	91
Table 32:	Type of Training Required of Health Administrators	92
Table 33:	Source of Training of Health Administrators	93
Table 34:	Agent Sponsoring Training For Administrators	94
Table 35:	Length of Training of Health Administrators	94
Table 36:	Responses of Health Administrators to Question, Was Training For Job Adequate?	95
Table 37:	Response to Question, How Should Health Administrators Be Recruited?	96
Table 38:	Respondents' Definitions of a Successful Administrator	97
Table 39:	Obstacles Leading To Failure As Health Administrator	98
Table 40:	Formal Public Health Training Since Becoming A Health Administrator	99
Table 41:	Responses Of Executive Officers Concerning Aspirations To Become A Health Officer	100
Table 42:	Reasons Given By Executive Officers For Not Aspiring To Be A Health Officer	100
Table 42A:	Explanations For Changes In Health Administrator's Position	102

Table		Page
Table 43:	Explanations For Lack Of Change In Health Administrator's Positions	103
Table 44:	Will There Be A Change In Health Administrator's Role?	104
Table 45:	What Changes Can Be Anticipated In The Future?	105
Table 46:	Membership In Professional Organizations	107
Table 47:	Reasons For Joining A Professional Association	109
Table 48:	Responses To Attendance At Professional Meetings	110
Table 49:	Offices Held In Professional Associations	110
Table 50:	Membership in Civic Organizations	111
Table 51:	Reasons For Joining Civic Organizations	112
Table 52:	Current Membership Of Respondents In Civic Organization.....	113
Table 53:	Frequency Of Attendance At Civic Meetings	113
Table 54:	Type Of Fraternal Association Membership	114
Table 55:	Reason For Joining Fraternal Association	115
Table 56:	Current Membership In Fraternal Association	115
Table 57:	Frequency Of Attendance At Fraternal Association Meetings	116
Table 58:	Membership In Church Association	116
Table 59:	Reasons For Joining Church Association..	117
Table 60:	Current Member Of Church Association ...	117

Table | Page

Table 61: Frequency Of Attendance At Church Association Meetings 118

Table 62: Major People and/or Health Administration Agencies Contacted 123

Table 63: Major People and/or Agencies Health Administrators Contact In Daily Work.... 124

Table 64: Major People and/or Agencies Health Administrators Contact In Their Work ... 127

Table 65: Major People and/or Agencies Contacted.. 129

Table 66: Problems With Job As Reported By Administrators 131

Table 67: Activities Or Tasks That Should Be Added As Reported By Health Administrators ... 132

Table 68: Reasons Given For Adding Activities 133

Table 69: Activities Or Tasks That Should Be Deleted 134

Table 70: Reasons Given For Deleting Activities .. 135

Table 71: Relationship To New Jersey State Department of Health 136

Table 72: What Is Liked Best About Job 138

Table 73: What Is Liked Least About Job 139

Table 74: What Changes Will Occur In Public Health 141

Table 75: How Will Changes Affect Administrator's Career? 143

Table 76: What Was Your Life Objective When Choosing A Career? 144

Table 77: What Are The Opportunities For Advancement In This Profession 145

Table 78: Father's Occupation 146

Table 79: Occupation Of Three Closest Friends Reported By Health Administrators 148

ABSTRACT

This study focused on the occupational role of the public health administrator in New Jersey. The social and occupational relationships and stresses of the group were analyzed sociologically to determine ideal and actual behavior patterns.

In New Jersey, non-medical administrators (licensed Health Officers and Executive Officers) may direct the activities of local boards of health. Although their role is not clear to the community, the occupation is eager for professional recognition. The number of non-medical administrators are increasing due to the changing emphasis in diseases and the shortage of physicians.

The data were drawn from published sources, personal experiences, and a questionnaire mailed to all (156) health administrators in New Jersey. Licensed Health Officers account for 118 of the total who serve approximately 570 municipalities. Fifty-six administrators were surveyed for this study (41 Health Officers and 15 Executive Officers).

Other data derived were family background, training, work experience, attitudes, recruitment, information regarding boards of health, the community,

and health and economic problems. Basic concepts used were social organization and socio-cultural structure (real and ideal behavior). Socio-cultural structure was determined through the formal structure ("official structure"), and informal structure (the questionnaire).

A theoretical model was formulated for the analysis of pertinent characteristics of the occupation: a) the model of behavior causation consisting of four major variables--cultural, personality, situational, interactional, b) role theory concepts. At the cultural level, norms, goals, attitudes, and values were examined in conjunction with role theory. Primary emphasis at the social organization level was on role stresses and the consequences of these stresses in the interaction process.

Frederick L. Bates' terms were used to define increasing levels of social cultural structures as related to a focal actor. Norms, roles, position, situs, and station were used to analyze expected behavior. Several forms of role stress were identified: role conflict, role inadequacy, role frustrations, role non-reciprocity, and role superfluity. These stresses are sociologically significant when a

majority of cases are subjected to a specific stress.

The study involved the sociology of occupations and medical sociology as sub-fields in the larger sociological arena. Both are concerned with the occupational role of public health administrators. The "professional" model devised by A.R. Carr-Saunders was used to describe the health administrator in his occupational role.

The hypotheses presented dealt with social relationships and aspirations of the occupation. Conclusions concerning these hypotheses follow:

1. Licensed Health Officers are playing an active role in community activities as members of local community agencies.
2. Because of informal but clearly defined relationship roles inherent in the administrators' occupational role, conflict is minimal.
3. Health Officers express a high degree of job and career satisfaction and are professionally oriented. In contrast Executive Officers do not see themselves as professional.
4. While the cultural norm of the occupation

has established requirements characteristic of professionals, administrators fail to reflect a professional image. This is less the case among licensed Officers who are receiving professional recognition.

5. Financial remuneration is not an important factor among administrators in determining occupational success.
6. Executive Officers hold little aspiration for achieving Health Officer status: they resent the emerging professional role of licensed Officers.

Other conclusions are that the non-medical Health Officers, like non-medical hospital administrators are demonstrating their capabilities in meeting community health needs effectively. As an occupational group health administrators are emerging as professionals due to changes taking place in the formal structure and in the sanctions from the State Department of Health (the dominant bureaucracy).

CHAPTER I

INTRODUCTION

A. Purpose of the Study

The object of this study is to focus on the occupational role of the public health administrator in New Jersey. More specifically, it is an exploratory study aimed at describing and analyzing, within a sociological frame of reference, the social and occupational relationships which are peculiar to the roles of this group. In attempting to gain insights into this occupational role, an effort will be made to:

1) determine the actual behavior of public health administrators as they express it themselves, and
2) establish the ideal behavior patterns of this occupational group -- the normative expected behavior.

B. The Problem

New Jersey is unique in its method of administering local health services for at least two reasons:

1) In the health organization pattern throughout the State there are both licensed Health Officers and Executive Officers, persons responsible for directing and administering the various local board of health activities in the community;

2) New Jersey is the only state whereby non-medical administrators may be licensed to serve as Health Officers or Executive Officers.

As an occupational group the public health administrative constituency is eager for recognition as a professional body, manifesting many of the characteristics typical of the "professional role". Yet in many instances their occupational role is not clear to the community at large. There is a tendency to class all health administrators into one collective group regardless of his specific training, license or responsibility. Those somewhat closer to the public health scene are much more sensitive to the frictions and conflicts created when all administrators of health services are classed together as one occupational body. Administrators who are licensed see themselves as members of an emerging profession struggling for recognition by other professional bodies and the community. Where the necessary credentials are lacking there is a tendency to feel resentment and antagonism toward the more ambitious associates. Compounding the issue is the fact that the public health administrator, while striving to function autonomously in a professional role, is also attempting to do so within the state health department organization

pattern which contains specified rules and regulations characteristic of a bureaucracy.

C. Significance of the Study

The fact of having a non-medical official in an occupational role, which, until recently was almost exclusively assigned to a member of the medical profession, is a peculiar phenomenon in the history of public health in the United States. Only in the last decade have we noted any successful infringement in this direction, with perhaps the greatest degree of success achieved by non-medical hospital administrators. Aside from this factor, there are other reasons for undertaking a sociological study of this occupation:

1. The shortage of physicians today makes it increasingly difficult to recruit them to fill the growing number of administrative public health posts available.

2. Public Health administrators constitute a relatively large occupational group and are to be found in communities throughout the nation.

3. The public health picture today is undergoing rapid transition in its organization and structure as well as in the health services which it now provides.

4. Many of the communicable diseases, once a major public health problem requiring medical attention and decision, have been placed under control; today, the degenerative diseases, along with social health planning and community medicine, seem to be more in focus.

5. An understanding of the social-relationships involved in the occupation of the public health administrator can be of considerable value to the occupation itself, in helping its constituency make social adjustments to improve the effectiveness of their health programs.

6. An understanding of the social relationships involved should aid local boards of health, the New Jersey Health Officers Association, and the Health Officers section of the American Public Health Association to appreciate and cope with the stresses involved in the occupation, as well as to aid in their relationships with the Medical Health Officer in ameliorating such stresses. Obviously, those who aspire to become members of this occupation stand to profit by any improvement which might be effected in the social organization of the work situation.

7. Further, from such a study, prospective members of this or allied occupations may gain some understanding of the social role involved before taking intensive training and entering into the occupation.

8. In addition, the occupation of the public health administrator lends itself as a case in hand through which human relations may be studied on an exploration basis for their theoretical significance.

    a. Because of its uniqueness, it offers the opportunity to view the process of professionalization, the striving for status and the efforts toward integration within the work situation.

    b. As an occupation, its members have obligations to two organizations; the state board of health and the local board of health. This duality provides an opportunity to investigate factors and principles which lead to the balance or dominance of power especially in the organization they administer.

c. The health administrator today represents an occupation which seems to be characterized by very diffuse orientation in an age of ever increasing specialization.

d. It is conceivable that a bureaucrat could function more effectively in a public health administration capacity than a medical doctor. Medical doctors are generally accustomed to working in a one-to-one relationship, whereas bureaucrats are trained to function in a system involving many relationships.

e. The community orientation of this group provides a setting which is large enough to study the action in a relatively complete social setting - yet the site is not so large as to be incomprehensible.

f. The public health administrator in New Jersey is caught between various expectations and situations which tend to prevent his role fulfillment; thus, the occupation provides an opportunity to study role conflict and other manifestations of stress in an occupation.

g. It is believed that the public health administrator, as he becomes exposed to the stresses cited above, provides a good model for the study of various social processes and social relationships.

D. Suggested Hypotheses

In light of the above, the following hypotheses will be presented:

1. Community groups and professions significant to the public health administrator tend not to perceive public health administrators as functioning in a professional role. Most specific decisions on community health matters are consequently subject to scrutiny and approval by these community groups and professions.

2. An important function of public health administrators lies in their ability to resolve conflicts arising over health policies and issues involving two or more health bureaucracies with whom the public health administrator must maintain a congenial relationship as part of his "work role".

3. Public health administrators who express a high degree of job and career satisfaction are more likely to see themselves as "professionals", conversely, those with a low degree of job and career satisfaction are less likely to see themselves in a professional role.

4. "Ideal behavior patterns" of public health administrators incorporate many characteristics usually associated with established professions. However, when playing out daily job roles, public health administrators fail to reflect this "professional image".

5. "Occupational success" is primarily defined by public health administrators on the basis of financial achievement rather than on the basis of job and career satisfaction.

6. Executive Officers tend to hold little aspiration for becoming licensed as Health Officers; they hold little aspiration for achieving "Health Officer" status.

E. The Data

The data for this study falls into three general categories:

1) published sources

2) personal experiences

3) use of questionnaire

1. Published sources

The various types of published data were reviewed and sub-divided as follows:

1) historical
2) laws and administrative publications
3) official reports
4) textbooks
5) professional and ideological writings

2. Personal experience

Because of this writer's personal experience in the field of health in New Jersey during the past fourteen years, an effort was made to draw from this experience, particularly where it provided clarification of certain aspects of the study.

3. Use of Questionnaires

Data obtained through the use of a questionnaire represent this study's most important source. A preliminary questionnaire was prepared and used on a limited basis for the purpose of testing its adequacy. From this experience, a refined instrument was developed containing both structured and open-ended questions. The questionnaire was mailed with a covering letter to 156 public health administrators, (118 Health Officers and 38 Executive Officers), during June 1969. Follow-up letters, one in July and one in August, were sent to

those not responding. Of the total mailed, six were not returned for the following reasons: retirement (2), position vacant (3), one respondent was away on an extended trip. Of the total questionnaires mailed, fifty-six (15 Executive Officers) were returned completed. These were processed for analysis. The names and addresses of the Health Officers and Executive Officers included in the study were taken from the List of Local Board of Health Employees, March 1968, New Jersey State Department of Health.

Since the study received the full cooperation and endorsement of the New Jersey State Department of Health and the New Jersey Health Officers' Association (see Appendix I, II), no difficulties were encountered in obtaining cooperation.

The methodological approach discussed above was developed around the "model of behavioral causation" and "role theory" (discussed in Chapter II). Therefore, the sources of data were related to this model.

The remainder of the study is concerned with the historical development of public health administration in New Jersey as background material, (See Chapter IV). Subsequent chapters are concerned with the formal structure and function of the profession, a description of the psychological factors, and a description of how health

administrators are recruited and trained for their occupation, their work situation, and their economic setting. The final chapter of the study is a conclusion.

The occupation of the public health administrator in New Jersey provides an opportunity to test empirically the practical use of certain sociological concepts, especially those involving behavioral models and role theory. It is hoped that this exploratory study will provide an opportunity for employing these sociological concepts as conceptual tools within a useful and meaningful theoretical framework. Lastly, the objective of this study is to contribute to the body of knowledge of occupations and to the field of medical sociology.

CHAPTER II

THEORETICAL FRAME OF REFERENCE

A. The Approach

The problem of defining the scope of sociology changes from a search for empirical boundaries to an effort to outline the distinctive conceptual frameworks to which empirical data are refined for assessment. This study attempts to determine the sociocultural structure of the health administration occupation by giving attention to actual behavior and the consequences of that behavior as it is expressed by the public health administrators themselves.

Expected behavior (sociocultural structure) is divided into two groups:

1) formal structure and
2) informal structure

The formal structure (the official structure of the public health administrator's position) was determined by studying and analyzing the various types of literature (laws, administrative publications and duties and responsibilities) as they exist in official training programs. The informal structure was examined through an instrument consisting of questions in the following key categories:

1) how do public health administrators act in various given situations, and
2) how do they think other group members feel they should act?

In addition, an attempt was made to obtain data which pertain to personal characteristics such as family background, training, work experience, attitudes and recruitment into the occupation. Attention was given to the situational factor and its relation to the public health administrator, by collecting select information concerning boards of health, the communities in which they work, the health problems within their counties and communities, and the general economic setting as it relates to the overall health program. The data were obtained through a questionnaire, a review of the available statistical sources, informal discussion with public health leaders, and other pertinent sources.

Since a large component of the occupational behavior of public health administrators involves social relationships, the interactional aspects of the occupation were also studied. Similar to other occupations, health administrators are involved in social relationships without which the occupation would be meaningless in a social system. These variables were studied by examining the dominant role around which the occupational <u>situs</u> of the

health administrator is built in terms of its relationship to the interactional variable.

The main focus of the study was not upon actual observed behavior, but rather on the felt consequences of acting out the roles. In this connection each respondent was asked questions involving role stress, role fulfillment, job and career satisfaction, occupational problems and changes.

B. Theoretical Aspects

An effort has been made to formulate a theoretical model which would enable us to present a view and analysis of the pertinent characteristics of health administration as a profession. This model can be formulated primarily in the terms discussed below.

1. At the social structure level:
   a. The model of behavior causation,[1] and
   b. Role theory[2]

Such an approach seems suitable for organizing the pertinent data concerning social behavior as well as for determining the degree and source of role conflict and stresses existing in an occupational structure.

2. At the cultural level: Select
   a. Norms
   b. Goals, and
   c. Attitudes and values.

These were examined, again using role theory.

Since it was not possible to observe and describe with any degree of accuracy the actual behavior patterns of health administrators because of the lack of time and the character of the experimental design, the primary emphasis at the social organization level was on certain role stresses in the interaction process. Actual role behavior is a process and it is during the process that actors make choices and take action, not only in the light of the cultural proscriptions, but also in terms of situations and their own personalities. It is also during this process that the health administrator feels certain stresses and assesses his role satisfaction, his role fulfillment and the problems of his work. Also it is here that differences are seen between real and ideal behavior patterns as well as between formal and informal social structures.

By accepting Frederick L. Bates' general definition of occupation,

> *as a cluster of roles performed by a given individual in return for pay*[3]

we can make use of certain concepts in the field of role theory for analyzing problems within occupations (following a logical progression of concepts from the microscopic to the macroscopic level of human behavior). Therefore certain concepts are defined in order to:

(1) explain their relationship to each other, and (2) pinpoint their selected usages.

C. Definitions of Major Terms

There are two sets of concepts incorporated here: the sociocultural structure and social organization (model of behavior causation), and the role theory concepts, particularly those reformulated by Frederick L. Bates. This two-fold approach in the study of the health administrator offers an opportunity to test empirically these concepts and formulations.

1. Sociocultural Structure.

The basic concepts used to refer to structure or uniformity in relation to social behavior are social organization and sociocultural structure. The essential differences between these can be found in terms of ideal and real behavior.

As a science, sociology is concerned with the uniformities or the structure[4] of social behavior. Structure refers to a set of determinate relations between parts. Human beings in society exhibit complexes of action, thought, and emotion which are shared by many individuals, repeated in many successive situations, and definitely related to other patterns in the social aggregate. According to Robin Williams, structure means:

> *an appreciable degree of regularity in relationships*[5]

Within the social structure framework, social processes provide the connecting tissue for both the social relationships among roles and positions and the empirical relationships between variables in the social structure.

The occupation of the health administrator provides an example of an elaborate patterning and coordinating of the action of many individuals, since it possesses a social structure which is easily recognized. Among these is the dissemination of health information and education which is provided to the community at large. The health administrator takes an active part with student groups, home economists and numerous community projects which involve local leadership; he also develops programs in conjunction with advisory groups. There exists a system of formal rules and expectations concerning the behavior of the health administrator. There also exists informal codes that supplement, modify or counter the official structure.

Peter Blau[6] defines *social structure* in terms of two kinds of relations among elements in an organized collectivity:

> (1) *the casual interrelations among variables that refer to attributes of the collectivity itself, not to attributes of its individual members, such as its size, the status structure in a community, or the government of a society;*
>
> (2) *the social interrelations among differentiated positions in the collectivity, such as division*

of labor or hierarchy of authority.

Social structure, therefore, to Blau, refers to recognizable collectivities of men.

This study tries to combine the elements suggested by Blau with Robin Williams' proposed two aspects of social structure, namely cultural structure and social organization.

Cultural structure refers to normative patterns and to the social organization, no matter what specific form the interaction may assume. Social structure is a broad generic concept which subsumes that which is known as cultural structure and organization; it refers to the normative aspect of social structure and deals with ideal behavior.[7] It can be considered *a blue print for action.*[8]

2. Social Organization

In social organization, emphasis is placed upon relationships and activities rather than upon the person. Since a person is a member of a group only in so far as certain activities or relationships are concerned, "social organization" refers to activities, while "organized groups" refers to persons. Taken at the lowest level of abstraction it represents the setting of such behavior into complex behavior systems such as groups, organizations, institutions, and communities. Social structure

in this context includes both:

a. cultural structure, which defines the situation in terms of goals and institutionalized means of attaining these goals, and

b. social organization, which refers to the activities and relationships by which these goals are to be sought.

In this study, however, social organization refers to the regularity of concrete human behavior:

> *there is organization precisely to the degree that the actions of individuals toward each other are recurrent and coordinated by the orientation of the acts of each to those of others.*[9]

Social organization is the organization of real behavior involving the four variables noted below in the model of behavior causation:

a) sociocultural structure

b) personality

c) situational

d) the interactional

All lead to the patterning disposition of human behavior.

3. Socio-cultural Structure

This study uses sociocultural structure to refer to the expected, normative or idealized patterns of behavior along with the associated system of goals, values and attitudes associated with these norms. Sociocultural

structure is not intended here as concrete behavior in itself, but represents only one factor which leads to behavior and which must be abstracted from it.

Structure contains parts that are arranged in an orderly manner. These parts in a sociocultural structure are the norms which may be conceptualized as being patterned or structured at various levels.

Human behavior, a subject which must be studied from many perspectives, takes into account both real and ideal expectations. The various dimensions of the structure of human behavior have been summarized by Bates:

> *We could list, then, in order of size, the units being visualized as parts of social structure. In doing this, we will have to distinguish between two kinds of unity, 1) human groupings on their parts, horizontal units and 2) human categories, vertical units.*[10]

This study is primarily concerned with a class of occupational public health administrators, or an occupational category. It is also concerned with the relations of these positions to each other as part of:

1) a common administrative hierarchy, and
2) the professional organization.

We are interested also in noting the relations of the occupation of the health administrator to the community and to the medical society as well as to the vertical dimensions of social rank (stratification) and social

function (institution). To achieve this type of analysis, we have used concepts of structural units which are basic at all levels of social groups or categories. As Bates notes:

> *regardless of the fact that the structure of society may be viewed on different levels almost all scholars agree that among the basic units in social structure are the 'social status' or position in the associative phenomenon of the 'social role'.*[11]

D. Role Theory

Any concept that fails to address to itself a set of properties and variables that are both distinctive and operational can not long maintain its appeal. In regard to our concern, one of the central problems is the need for a family of role concepts which include regularities in interpersonal relationships - both overt behavior and psychological state (relationships of persons, attitudes, and expectations).[12]

In recent years there has developed an increasing interest in the field of role as reflected by the growing literature and vigorous research endeavors. Based on these developments many feel that the study of role may well be on the threshold of becoming an area of specialized inquiry.

1. Significant Role Theorists

Thomas and Biddle have noted that the field of

role has unfortunately come to be known as *role theory*. The implication that there is actually more theory than fact is the case. To them there is no one *grand theory* although the field entertains speculations, hypotheses and theories about particular aspects of the subject. To them the only aspect of role theory that is unique is its language - its terms and concepts - since the domain of study and perspectives of role are shared with various disciplines of behavioral science.[13]

Their appraisal of the current state of the field indicates that:

> *It would be realistic for role analysis to work toward establishing role theory as a distinct specialization in behavioral science, one which can maintain close ties with the particular disciplines that in the past have contributed so greatly to it and with the practical endeavors that consume and apply its knowledge.*[14]

In order to pursue this objective, they feel that future efforts will involve consolidation of present gains as well as many innovations.

Other impressive models on role theory have been proposed by Gross, Mason, and McEachern[15]; Robert K. Merton; and Frederick L. Bates.[17]

In their *Exploration in Role Analysis* (1958), Gross *et al* recognized the importance of the concept role in assuming an important position in sociology, social

psychology, and cultural anthropology. They noted that the concept has been used as:

1) a central term in conceptual schemes in the analysis of the structure and function of a social system, and

2) as a means of explaining individual behavior.

They attempted to force a closer link between theoretical and empirical analyses in the study of roles, and proceeded by reviewing the ways role has been conceptualized. Their major contribution lies in a scheme which gives emphasis to intermediary and peripheral concepts. They developed a "role language" intended for application to individual behavior, cultural and social phenomenon, and role consensus. Their scheme is tested by investigating the school superintendency role.

The conceptual language formulated by Gross *et al* includes: a) position, b) expectations, c) role, role behavior and role attributes, and d) sanctions and permits examination of a formal position and its counter positions in terms of ideal behavior and real behavior. However, it does not allow for examination of roles in multi-grouping, community and societal structure, and it is centered around a focal position and its counter positions with no reservations for structural concepts other than position role and expectations.

Robert K. Merton attempted to apply structural role concepts to reference group theory. He implies that social status is a distinct position assigned to an individual both within and among social systems. He introduces the concept *status-set* (a complex distinct position assigned to individuals both within and among systems). Merton has analyzed the structural character of roles by examining the structural context of reference group behavior, and by producing concepts which fit into a logical structural framework. He uses the terms of status and role, bringing into focus new dimensions to the structural framework. In addition to the concepts norms, role and status, he also introduced *role-set* and *status-set*, as complements of roles and statuses. These are structural concepts, referring to parts of the social structure at a given time. His terms *role sequence* and *status sequence* add the dimension of social change to the study of social structure.

Merton's concepts provide a basic framework for the analyses of role with greater precision. His concern is with *reference group behavior* only. Like Gross *et al*, he fails to develop a framework which would be applicable to multi-group or community structure.

Frederick L. Bates was among the first to recognize the need for a workable conceptual framework containing well defined concepts for role analysis. He

has developed a model of behavior causation which incorporates four major groups of independent variables considered important in exploring human behavior. These are a) cultural (comprised of norms), b) personality (comprises the traits which form systems of qualities that are interrelated in a dynamic way), c) situations (the total objects in the environment that the actor perceives, and d) interaction (the basic unit being the stimulus-response).

Bates has also developed a role theory approach to the structure of occupations, representing a culmination of a series of articles on the various aspects of role theory and structure. His formulations attempt to classify structural concepts and avoid further confusion concerning the use of the term *status* by including the concept *position* in his framework. A basic concern has to do with the place of the actor in group structure. Recognizing this he develops a framework for describing the place of an actor when analyzing role relationships in groups structure, a multigroup structure, and a community or societal structure.

Bates' formulations provide a logical conceptual scheme for the examination of social relationships. The applications of these concepts make possible the definition and analysis, within a single frame of reference, of the conceptual and structural relationships of norms, roles, statuses, positions, situses, and stations. These concepts,

when used in role analysis, make it possible to extract and study analytically each level of structural concepts, and to study one individual situs of an actor of a specific position. Because of this, the field of role analysis is significantly advanced.

Gross *et al*, Merton, and Bates have provided refreshing views on the definitions of role, position and group structure. Each has given consideration to the way in which roles relate to each other in role systems, regardless of their content and regardless of the actors and their identification with reference groups. There are common elements which cut across the structure of each of their schemes. Although there are minor variations in their definitions, all take substantially the same point of view.

2. Concepts of Role Used in this Study

The model for describing and analyzing the health administrators in this study was general role theory since that seems well adapted for organizing the pertinent data in a meaningful way. Role theory, however, has not been offered as a complete explanation of human conduct, nor as a full description of man. Rather it is viewed as an analytical approach in sociological analysis and as a basic element in social structure.

This study uses Bates' terms to define increasing levels of sociocultural structures as related to a focal actor. These terms (norms, roles, position, situs, and station) are used to categorize and analyze expected behavior of the public health administrator and are defined as follows by Bates:

1) Norm: a patterned or commonly held behavior expectation, a learned response, held in common by the members of a group.

2) Role: a part of a social position consisting of a more or less integrated sub-set of social norms which is distinguishable from other sets of norms forming the same position.

3) Status: a part of a social position consisting of all the roles which are played by the occupant of a single alter status.

4) Position: a location in a group structure which is associated with one or more statuses, containing one or more roles which are composed of norms.

5) Situs: a set of positions customarily occupied by the same actor in a multi-group system (occupational situs) which consist of all positions a person who pursues a given occupation is expected to occupy.

6) Station: the location of an actor in the total structure of a community or society consisting of a collection of situses which in turn are composed of a collection of positions comprising one or more status composed of one or more roles.[18]

Several forms of role stress may arise in a social system if we define an occupation in terms of a system of roles. There are five distinct types of role stress that can be identified:

1) role conflict: a condition of stress within the sociocultural structure of a social system.

2) role inadequacy: a conflict between the sociocultural variable and the personality variable.

3) role frustrations: that situation in which roles are performed containing elements which prevent or impair role performance.

4) role non-reciprocity: that situation in which two norms are assigned to different actions and are not reciprocal to each other.

5) role superfluity or saturation: that point at which the number of expectations of an individual exceed the capacity of the normal individual to perform, even in the absence of personal inadequacies.

The role stresses defined above have application to a single actor as well as to a majority of a class of actors. When the majority of cases are subjected to a specific stress, that stress is significant from a sociological point of view.

Social structure accounts for how individuals should act and how individuals do act. The ideal behavior can be found in the cultural structure while the real behavior lies in the social organization. By using social structure models in relation to role analysis, the investigator is alerted to the significant variables.

CHAPTERS II NOTES AND REFERENCES

[1]Frederick L. Bates, *The Structure of Occupations: A Role Theory Approach* (Raleigh, North Carolina State University, 1967).

[2]*Ibid.*

[3]*Ibid*, p. 4.

[4]Robin M. Williams, Jr., *American Society: A Sociological Interpretation* (New York: Alfred A. Knopf, 1952), pp. 20-21;

Structure is: *a relatively fixed relationship between elements, parts, or entities, as, for example, the structure of a house, an animal, or a plant, containing gross observable parts that maintain a fixed relationship to one another: for an appreciable time...*

To demonstrate the structure one need only to show a recurrence of elements related in definite ways. In the interests of realism it is best to speak of the structure of social phenomena only where there is an important degree of continuity - where human activities are so patterned (recurrent) that we can observe a group's standardization persisting, although changing over a considerable time.

[5]*Ibid.*, p. 20.

[6]Peter Blau, "Objective of Sociology" in Robert Bierstedt, ed., *A Design for Sociology: Scope, Objectives, and Methods* (Philadelphia: The American Academy of Political and Social Sciences, Monograph 9, 1969) pp. 62-63.

[7]Robin M. Williams, *op cit.*, pp 44-45,

> *cultural structure (is) conceived as a series of norms or ideal patterns to which people are oriented. The cultural web of shared norms, goals, and values, is one of the major determinants of social action. However, the interactions of persons in specific situations seldom perfectly follow the cultural blue print and much patterning*

> *is directly related by cultural norms.... cultural regulation occurs where normative standards are maintained by the diffuse action of the whole social group - as in the mores of a small rural community. Sanctions are meted out through diffuse consesus; the mechanisms of enforcement of norms are non-nucleated; no particular individual group is clearly responsible for maintaining the accepted patterns. On the other hand, a great many values and norms are specifically allocated to particular functionaries and enforcements, fostering and supporting. To the degree that regulation is just focalized, cultural structure may be said to pass over into social organizations.*

[8]*Ibid.*, p.33.

[9]Bates, *op. cit.*, p. 21.

[10]Frederick L. Bates, "The Nature of Social Structure and Social Organization" (unpublished manuscript, Louisiana State University, Baton Rouge, 1959). p. 10, as quoted in Harold L. Nix, "A Sociological Analysis of the Roles and Values Orientation of an Occupation: Vocational Agricultural Teaching", (unpublished doctoral dissertation, Louisiana State University, 1960), p. 24.

[11]*Ibid.*

[12]Theodore Newcombe, in Thomas and Biddle, *Role Theory: Concepts and Research* (New York: John Wiley and Sons Inc., 1966) p. V and VI.

[13]Thomas and Biddle, *op. cit.*, pp. 14-17.

[14]*Ibid.*, p. 17.

[15]Gross, Neil, Ward S. Mason and Alexander M. McEachern, "*Exploration in Role Analysis: Studies of the School Superintendency Role* (New York: John Wiley and Sons, Inc., 1958.

[16]Merton, Robert K., *Social Theory and Social Structure*, (Glencoe, Illinois: The Free Press, 1957).

[17]Bates, *op. cit.*, pp. 15-16.

[18]Bates, "An Outline of Structural Concepts", *op. cit.*, pp. 1-3.

CHAPTER III

SOCIOLOGY OF WORK

This study attempts to sociologically analyze the occupational role of the public health administrator in New Jersey by investigating the social and occupational relationships peculiar to this occupation, and by discussing the suggested hypotheses outlined in Chapter I. To do this effectively, a review of the area of the sociology of work has been undertaken. This chapter covers the salient features of this sociological specialty, and attempts to lay the foundation for connecting the concepts to the actual work situations as experienced by public health administrators (Chapter 5).

A. The General Conception of Work

A fundamental distinction between man and primates is that man plays many roles. Basic to these roles is the fact that a) man is a worker, and b) the kind of work he engages in affects all aspects of his life including how he views himself.

1. The Work Role

Students of human behavior are becoming increasingly aware of the significance of work in relation to a) the total social life and b) the need for patterns of readjustment which work requires. The work

role in present society is best characterized by a progressive division of labor and function. The progressive division of labor has been a major force in contributing to the complexities of social life, and accounts for the individual's participation in a smaller segment of the social system in which he is integrated.

> *...the work a man does, the conditions under which his work is done, the wage he receives for doing it determine in great measure the circumstances of his life*[1]

2. The Notion of Occupation

Caplow has stated that,

> *Occupational position is an important factor in the determination of individual prestige and in the allocation of social privileges. There appears to be a consistent tendency for occupational identification to displace such other status-fixing attributes as ancestry, religious office, political affiliation, and personal character. Each of the three several trends which can be discerned in modern industrial society (aggregation, differentiation, rationalization) seem to lead toward increasing emphasis on the importance of the occupational level.*[2]

Caplow's comments reflect the significance which occupational roles play in assigning to individuals and their family a reference point within the stratum of his society. Occupational studies, then, are important from the practical as well as from the theoretical standpoint. Most members of society are constantly engaged in different types of work roles.

It has been suggested by Salz[3] that the notion of occupation incorporates three sets of conditions - technological, economic, and social. He defines an occupation as:

> *That specific activity with a market value which an individual continually pursues for the purpose of obtaining a steady flow of income; this activity also determines the social position of the individual.*

"Occupation", like "work" is a basic condition and generic term. In sociological terms, occupation involves a degree of cooperativeness, a degree of consciousness of kind and a reciprocity between the acting individuals in their occupation. Thus, ideology and identity are central to the sociological notion and experience of occupation. Included as integral components of the sociological concept of occupation are:

> *career, status, prestige, mobility, images, clients, culture, structure, recruitment, remuneration, and control.*[4]

3. Occupations and Professionalization

In addition to professions *per se*, the aura of professionalism appears to be pervasive in urbanized society. The notion of professionalism far exceeds professions, thus constituting a model for occupational aspirations for most workers in commercial and industrial jobs.

While the basic characteristic of the professions

appear to be more or less uniformly recognized today, specific decisions as to which occupations are professions usually depend upon which characteristics are emphasized. Generally speaking, the professions are viewed as intellectual occupations based upon a long process of formal assimilation of theoretical knowledge upon which professional activity is based.[5]

The professions as a special class in the family of occupations appear to be rooted in the traditionalism of medieval Europe. Among occupations, the professions have made a relatively successful transition from the protection of the cloister to the protection of the community. While the guilds of merchants and artisans were destroyed by a changing social order as a result of industrial capitalism, the guilds of professionals managed to retain an honorable and relatively unchanged position in the community. And despite changes such as rising capitalism, restructuring of the class system, increasing importance of the market, and the redistribution of political power, the professions maintained their guild-like character. As Nosow and Form[6] note, the characteristics associated with the professions are the same as those of the guild:

a) control over the work situation

b) regulation of relationships among colleagues

c) maintenance of an occupational ethic

d) rules governing relationships between guild member and customer (client)

e) special protection by the broader community

B. The Professions

1. The Profession as an Ideal Type

Around the turn of the 20th Century, Max Weber called our attention to his concept of *ideal types*. Today this conception represents a valuable methodological tool in describing changes in political organizations as movement from *traditional* to *rational-bureaucratic forms of administration*. These *ideal types*, or *models* enable us to (1) describe administrative behavior, and (2) permits us to locate particular administrative patterns along a continuum ranging from traditional forms at one end to rational-bureaucratic patterns at the other. Since the elements in the continuum are unidimensional, an organization can be described as being characteristically more bureaucratic in comparison to another organization. Here then lies the basis for making certain predictions about the behavior of these organizational entities and about the individuals within them.

Students of occupational institutions have made use of Weber's ideal types. In recent years attempts have been made to establish a classification basis which

focuses upon the way human beings tend to organize their work activities along a career perspective. In modern industrial society where people tend to move from one job position to another and from one employer to another, there is often some continuity between one job and the next to which they take their acquired skills and knowledge. When they become self-conscious of this continuity, they begin to speak of a "*career*", reflecting a trend toward more formal occupational codes of behavior in many lines of work. This trend has been described as a movement toward professionalization.[7]

When viewed as an ideal type of occupational institution, the profession does not exist in reality. However, it provides the model of the form of occupational organization that would result if any occupational group became completely professionalized. For example, a review of occupational groups today would show many assuming some of the characteristics normally attributed to the traditional professions in Western society, i.e., ministry, law and medicine. Also, many groups usually considered within the context of the tratiditional professions tend to fall short of the professional model in many respects. Using the ideal-type conceptualization, occupational groups can be analyzed and described in terms of the concept

professionalization, (assuming that occupations can be placed somewhere on a continuum ranging from the *ideal-type profession* at one extreme to the completely unorganized occupations or non-professions at the other extreme). For as Vollmer and Mills[8] state,

> *professionalization is a process that may affect any occupation to a greater or a lesser degree.*

Perhaps the notion of professionalization is best summarized by Vollmer:[9]

> *Professionalization represents an indigenous effort to introduce order into areas of vocational life which are prey to the free playing and disorganizing tendencies of a vast, mobile and differentiated society undergoing continuous change. Professionalization seeks to clothe a given area with standards of excellence, to establish rules of conduct, to develop a sense of responsibility, to set criteria for recruitment and training, to ensure a measure of protection for members, to establish collective-control over the area, and to elevate it to a position of dignity and social standing in the society.*

2. <u>The Elements of Professionalization</u>

Among the first social scientist to systematically analyze the transition of diverse occupations in terms of the process of professionalization was A.M. Carr-Saunders who in 1928 delivered the Herbert Spencer Lecture at Oxford on the development of *professionalism* in its historical perspective. This was five years before publishing his famous treatise with

P.A. Wilson, *The Professions*.[10]

In the Oxford lecture, Carr-Saunders defines professionalization in terms of specialized skill and training, minimum fee or salaries, formation of professional practice. He notes that all special interest groups are not necessarily professional in character, and distinguishes professional associations by the degree to which they seek to establish minimum qualifications for entrance into professional practice or activity, to enforce appropriate rules and norms of conduct among members of the professional group, and to raise the status of the professional group in the larger society.[11]

In his lecture he notes that it was not until the 19th Century that new professions began to achieve recognition, pointing out that what is called a profession emerges when a number of persons are found to be practicing a definite technique founded upon a specialized training. A profession may perhaps be defined as:

> *an occupation based upon specialized intellectual study and training, the purpose of which is to supply skilled service or advice to others for a definite fee or salary.*

Specialized intellectual training is one criterion of a profession, and remuneration another. He notes that it is not difficult to account in general for the emergence

of new professions since large scale organizations favor specialization. Specialized occupations have arisen around the application of the new scientific knowledge.

Carr-Saunders comments that as soon as a profession emerges, the practitioners are moved by the recognition of common interests to attempt to form a professional association. These attempts are by no means immediately successful. The tendency is towards the dominance of a single professional association in each profession. Some professions have never been troubled by the rivalry of associations. The better equipped members of an emerging profession want to be distinguishable, and to that end they form associations, membership of which is confined to those possessing certain minimum qualifications. With few exceptions, professional associations can be said to be exclusive only in the sense that they exclude the *unqualified*. In professional associations the members mutually guarantee not only their competence but also their ethical behavior.

In his survey of the history of the professions in modern times, Carr-Saunders found that when a profession became clearly defined the competent and responsible practitioners form an association,

> *two of the chief objectives of which are to bring up the qualifications of all who hold themselves out as practicing*

the craft to a certain minimum standard and to enforce rules of honorable conduct.[12]

According to Carr-Saunders, groups organized for industrial, commercial, and administrative purposes occupy the most prominent positions in the field of view today. He notes that there are reasons for anticipating that groups organized around vocations will come to assume at least equal prominence. Of these the most important is that professional associations are groups organized around the most enduring of men's practical interests. *A man's permanent attachment is to his profession.* Professions evolve, and in consequence their organizations are modified, but on the whole they change less rapidly than do the institutions in which men practice their crafts.[13]

Greenwood[14] was among the first to attempt to identify and describe essential elements in the ideal-type profession. Noting that professions occupy a position of great importance on the American scene, he states that in a society such as ours, characterized by minute division of labor based upon technical specialization, many important features of social organization are dependent upon professional functions. Professional activity is coming to play a predominant role in the life patterns of increasing numbers of individuals of both sexes,

occupying much of their waking moments providing life goals.

To Greenwood it is no wonder that the phenomenon of professionalism has become an object of observation by sociologists, whose approach to professionalism is one that views a profession as: an organized group constantly interacting with the society that forms its matrix, performing its social functions through a network of formal and informal relationships, and creating its own set culture requiring adjustments to it. After reviewing the sociological literature on occupations, he proposes five elements which he believes constitute the distinguishing characteristics of a profession:

1) systematic theory
2) authority
3) community sanction
4) ethical codes
5) culture

While Greenwood outlined his discussion in terms of professions and non-professions, he also points out that there are no clearcut distinctions between them. He notes that the model of a profession can provide criteria for evaluating the degree to which an occupation has become professionalized.

Hall[15] calls our attention to two related but often noncomplementary phenomena affecting the social structure of Western societies, namely (1) the increasing professionalization of the labor force, i.e., occupational groups that have held the status of *marginal professions* which are now intensifying their efforts to be acknowledged as full-fledged professions, and (2) occupations that have emerged rather recently, as well as some that have not previously been thought of as professions which are also attempting to professionalize. He also notes that work in general is becoming increasingly organizationally based, both for the established profession as well as for the occupations in the process of professionalization.

According to Hall most discussions about the nature of professionals typically revolve around the professional model. This model consists of a series of attributes which are important in distinguishing professions from other occupations. He points out that the attributes of the professional model are of two basic types. The first consists of those characteristics which are part of the <u>structure</u> of the occupation, including formal education and entrance requirements. The second type is <u>attitudinal</u>, including the sense of calling of the person to the field and the extent to which he uses

colleagues as his major work reference.

Wilensky[16] has carefully examined the structural aspects of the professional model. In doing so he has noted that occupations pass through a rather consistent sequence of stages on their way to achieving the status of professions. Among the attributes included by Wilensky are the following:

(1) Creation of a full-time occupation- involves the performance of functions which may have been performed previously, as well as new functions, and can be viewed as a reaction to needs in the social structure.

(2) The establishment of a training school - this reflects both the knowledge base of a profession and the efforts of early leaders to improve the lot of the occupations. In the more established professions, the move is then followed by affiliation of the training school with established universities. In the newer professions, university affiliations are concurrent with the establishment of training schools.

(3) Formation of professional associations - the formation of such associations often is accompanied by a change in the occupational title, attempts to define more clearly the exact nature of the professional tasks and efforts to eliminate practitioners who are deemed incompetent by the emergent professionals. Local associations write into national associations after a period of some political manipulations. As stronger associations are formed, political agitation in the form of attempts to secure licensing laws and protection from competing occupations becomes an important function.

Once the structural prerequisites of professionalism listed above have been met, the approach or attitude taken by the practitioner toward his work becomes an important consideration. In this respect, Hall offers the following attitudinal attributes:

(1) The use of the professional organization as a major reference - this involves both the formal organization and informal colleague groupings as the major source of ideas and judgments for the professional in his work.

(2) A belief in service to the public - this component includes the idea of indispensability of the profession and the view that the work performed benefits both the public and the practitioner.

(3) Belief in self-regulation - this involves the belief that the person best qualified to judge the work of a professional is a fellow professional, and the view that such a practice is desirable and practical. It is a belief in colleague control.

(4) A sense of calling to the field - this reflects the dedication of the professional to his work and the feeling that he would probably want to do the work even if fewer extrinsic rewards were available.

(5) Autonomy - this involves the feeling that the practitioner ought to be able to make his own decisions without external pressures from clients, those who are not members of his profession or from his employing organization.[17]

By taking into account both the structural and attitudinal aspects of professionalism, Hall feels that a base has been established for a professional model since: (1) occupations vary in the degree to which they

are professionalized, and (2) even among the established professions, members vary in their conformity to the professional model in both the structural and attitudinal attributes. While the established professions, such as medicine and law, appear to fit this professional model in most ways, the newer emerging professions are not as professionalized in the various attributes.

3. The Semi-Professions

Etzioni[18] has given the term *semi-professions* for that group of new professions whose claim to the status of doctors and lawyers is neither fully established nor fully desired. In general their training is shorter, their status is less legitimated, their right to privileged communication less established, there is less of a specialized body of knowledge, and they have less automony from supervision or societal control than *the professions*. According to Etzioni the term semi-profession is not intended to be derogatory, and is in fact less derogatory than the term sub-profession.

To Etzioni the semi-professions involve three areas of sociological study: that of organization in which practically all semi-professionals are employed; that of demography, because the majority of the labor force we deal with is female and its demographic attributes significantly affect our subject; and that of conflict analysis,

because the normative principles and cultural values of professions and organizations are not compatible. He notes that the semi-professionals' efforts to change themselves in order to more fully live up to the claims, generate a major source of tensions because there are several powerful societal limitations on the extent to which these occupations are willing to be fully professionalized.

4. Professionalism and Bureaucracy

Vollmer and Mills[19] have pointed to the need for sociologists to examine interaction patterns of professionalized occupation roles and complex organizations. They also feel a need for concern with political and legal aspects of professionalization, as well as the interrelationship of professionals and the government.

Generally speaking, the term professional refers to a person who by virtue of long training is qualified to perform specialized activities autonomously, and is relatively free from external supervision or regulation, while the term bureaucrat refers to a person performing specialized but more routine activities under the supervision of officials organized in a hierarchical fashion.

These general definitions imply different arrangements for organizing work. Using these broad

definitions, we see that if a person is trained to function as a *professional* but finds himself in the role of *bureaucrat*, the possibility of conflict arises.

When professional workers attempt to operate within a bureaucratic structure, conflicts and tensions are generated, and various attempts at reconcilation and accommodation tend to be made. The precise nature of the problems and solutions vary with the characteristics of the particular professional groups and employment setting examined. Nonetheless the problems are present in some form in all circumstances where professionals are employed by bureaucratic organizations.[20]

Yet no profession has escaped the advancing tide of bureaucratization. While the salaried professional differs markedly from the independent professional described in past literature, he is different primarily because he works under different circumstances. One significant feature is the fact that his work is subject to the evaluation and control of other individuals who are not necessarily members of his professional group. These are managers, whose authority governing the work of all employees, including highly professionalized employees, derives from the legitimizing principles of bureaucratic administrations. In contrast the professional model of behavior assumes that work is controlled

in terms of ethical standards determined by colleagues in a professional association, rather than by managers in an administrative hierarchy. This difference provides the basis for a considerable degree of role conflict when professional individuals become salaried employees in complex organizations -- or conversely, when certain categories of employees in bureaucratized organizations become more professionalized. Vollmer and Mills note that while:

> *many professions are becoming bureaucratized, many bureaucracies are also becoming professionalized.*[21]

The increasing prevalence and social significance of the kinds of work carried out by professionals in bureaucratic organizations is of interest to the sociologist, particularly since these structures can shed light on certain theoretical problems in understanding organizations. Scott has distinguished two such problems: in the first he notes that

> *professionals participate in two systems - the profession and the organization - and their dual membership places important restrictions on the organization's attempt to display them in a rational manner with respect to its own goals.*

Secondly, he notes that

> *the professions and the bureaucracy rest on fundamentally different principles of organization, and these divergent principles generate conflicts between professionals and*

their employees in certain specific areas.[22]

Theorists, according to Scott, are coming to realize that if an organization is to operate as a rational structure, it must be relatively insulated from its surrounding institutional environment. He feels that the organization must have the power to select recruits and control their contributions in such a way as to implement the system's goals. However, this is difficult in cases where organization members participate in more than one system having relevance for the performance of their occupational role.[23]

This phenomena has been recognized by others. For example, Kornhauser has noted that to examine professionals in bureaucracies is to examine the

relation between two institutions, and not merely between organizations and individuals.[24]

Without doubt, two institutions <u>are</u> in fact involved in the relation between professionals and bureaucracies. Furthermore, both systems are based on fundamentally different principles.

Scott[25] proposes two models as alternative ways of organizing a complicated job toward satisfactory completion. His first approach is to instill in each worker <u>all</u> the basic skills required for doing the work together with the norm and standards which will

govern his performance. The second alternative is to divide the task into its institutional activities and to train some workers to perform certain of these activities and other workers to perform different ones. In the latter approach norms and standards are not internalized, so that a system of rules which specifies how the work is to be done will be necessary, and therefore some worker must be given the job of interpreting and enforcing the rules. In the first alternative external control is difficult to effect since workers possess complete skills.

The first model is an attempt to describe some of the features associated with a professional system. The second model describes some of the characteristics of the bureaucratic organization.

On the one hand we have the professionals, usually characterized as persons trained in professional schools, possessing complete skills and special knowledge, and equipped with internalized control mechanism. In contrast we have the bureaucrats who are usually characterized as relatively specialized functions and as operating in a hierarchical structure under a system of formal rules.

By delineating the two models above, Scott attempts to give emphasis to the fact that professional

and bureaucratic principles provide alternative approaches to the organization of tasks. Using the two models as the framework in analyzing and describing the causes and types of conflict which are reported to occur wherever professionals are employed by bureaucracies, he then focuses his attention on the type of conflicts generated, since he feels they can help illuminate the contrast between the two systems. He suggests four distinct areas of conflict:

1) the professional's resistance to bureaucratic rules

2) the professional's rejection of bureaucratic supervision

3) the professional's resistance to bureaucratic supervision

4) the professional's conditional loyalty to the bureaucracy.

Scott contends that these areas of conflict exist and persist because the professions as groups inculcate their members with certain values and support them in their conflicts with the organization. It is because of these efforts on the part of professional groups that the organization is less a free agent in dealing with this class of employee.

CHAPTER III - NOTES AND REFERENCES

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CHAPTER IV

PUBLIC HEALTH ADMINISTRATION

Public health can be defined as organized activity directed to the community to reduce disease and disability, to strengthen and improve health, and to prolong life. Thus, there is a relationship between a community and the public health administrator which is similar to the relationship between the patient and the physician.

A. Brief History of Public Health in New Jersey

A brief history of public health in New Jersey is outlined here in order to describe the formal structure within which public health administrators attempt to meet the ideal of public health as defined above. New Jersey is unique in its administration of local health services since it allows non-medical administrators (licensed Health Officers and Executive Officers) to direct the activities of local health departments. Regardless of training or licensing, health administrators are grouped into a collective whole which sometimes results in conflicts, and always in a disparity between "real" and "ideal" behavior.

In 1903, New Jersey was the first state to license municipal health officers and sanitary inspectors,

and the first state to license non-medical local administrators on the basis of specified qualifications. Health administrators in New Jersey have been of three types: physicians (mostly part-time), college trained non-medical health administrators, and those without formal training who had served apprenticeships as sanitary inspectors and communicable disease inspectors.

Public health services have always been and still are based on the municipality which is responsible for all fiscal, legislative, and law enforcement matters. New Jersey still remains a maze of tiny municipalities employing many part-time health administrators to service a number of municipalities.

The New Jersey statutes provide for the licensing of Health Officers as well as other public health personnel by the State Department of Health. The State Sanitary Code requires that the Board of Health of each municipality of more than 10,000 population employ a licensed health administrator to be its Executive Officer and its general agent in the enforcement of health laws and ordinances. Despite these provisions, there were only 197 licensed health administrators employed by the 568 municipalities in the state in 1963. Of these, only 97 were full-time. By 1968 there were 340 municipalities serviced by 116 licensed officers.

The public health administrators of thirty to fifty years ago came to their positions from three distinct backgrounds. First were the physicians who, with few exceptions, served on a part-time basis; second were the college-trained non-medical health administrators (some of whom had studied at the Massachusetts Institute of Technology). This small but well-trained group brought to New Jersey the seeds of professional public health administration. They set the pattern for the generation of non-medical health administrators who provide leadership today.

The largest number of health administrators, however, were in the third group: the apprenticeship-trained. The New Jersey Health and Sanitary Association organized in 1911, and the Annual Conference of State and Local Health Officials, sponsored since that year by the State Department of Health, represented the major educational opportunities for the practicing health administrator. Both the Health and Sanitary Association and the Health Officers Association were active in sponsoring and supporting new health legislation. Leadership was also provided by a group of non-medical epidemiologists and administrators in the Bureau of Local Health Administration (now the Division of Local Health Services) of the State Health Department.[1]

Public Health services in New Jersey are still based on the municipality. Here lies the responsibility for local accomplishment, according to a plan written into law over a century ago. It is in the municipality that all fiscal, legislative and enforcement powers are vested.

In New Jersey, as in many other states, full municipal responsibility for local health services poses one of the most persistent and troublesome problems in the whole field of health. For example, New Jersey is divided into 568 municipalities. Less than twenty have a population of 50,000 or more. Hundreds have fewer than 5,000 inhabitants; 140 municipalities have fewer than 2,000. Although New Jersey shows a rapid rate of growth, making it possible for some municipalities to support (both from a population as well as an economic standpoint) a fairly adequate range of services - this has yet to change the basic character of the state. New Jersey still remains a maze of tiny municipalities - and the trend appears to be toward increasing the already large number rather than consolidating.

Added to this complexity is the fact that, in many instances, one individual is employed as a part-time health administrator for a number of municipalities.

Usually, the part-time official has regular full-time employment elsewhere, limiting his availability as a health administrator to evenings or weekends. If he is serving several municipalities, his availability in any one is necessarily reduced.[2] Nonetheless, New Jersey does have legislation which permits various types of more acceptable cooperative public health activity between two or more municipalities.

The Local Health District Act of 1951 authorizes the provision for cooperative local health services in the form of complete functional consolidation. Under this system, either a county local health district or a consolidated local health district may be formed. Upon the creation of either type, the pre-existing local boards of health in the cooperating municipalities cease to exist and are replaced by a new district board of health.

The Consolidated Municipal Services Act, which is a general statement providing for the consolidation of municipal services, originally contained the requirement that consolidation of municipal services could be carried but only if approved by the voters in a referendum. The Act was amended in 1960 striking out the referendum procedures and substituting a provision for similar ordinances in the consolidating municipalities.

A second method of providing cooperative local

health services is through the Regional Health Commission, established in 1938. This method indicates the wide-spread desire in New Jersey to cooperate, if at all possible, but in such a way as to retain local boards and local identity. Since the regional health commission approach does just this, it tends to be more acceptable to New Jersey residents.

Still another means of providing cooperative local health services is through the county coordinator system. This approach finds its legal basis in a 1929 statement permitting contractual arrangements among municipalities, counties, and private agencies for public health purposes. The board of chosen freeholders (official governing body) of a county may appoint a county health coordinator. Municipalities in the county may then enter into contracts with the county. Under these contracts, the coordinator is appointed as health administrator for the municipalities and performs services jointly agreed upon, for which the municipality pays the county.[3]

In 1960 a bill was introduced in the New Jersey State Legislature which would have permitted the boards of chosen freeholders in certain counties, by resolution, to establish a county board of health and bureau of vital statistics. At first the bill applied only to a few counties which border on the Atlantic Ocean or the Delaware

Bay and which have a population of less than 200,000, but has since been amended to affect all counties throughout the state.

The New Jersey statutes provide for the licensing of health officers, as well as other public health personnel, by the State Department of Health. The State Sanitary Code requires that the board of health of each municipality of more than 10,000 population employ a licensed health officer to be its executive officer and its general agent in the enforcement of health laws and ordinances. Other laws relate to salary, tenure, removal procedures, and various employment conditions of health administrators. To be admitted to the health administrator's examination, an applicant must meet the basic requirements of education and experience set by the Public Health Council of the State Department of Health. Each application is reviewed by the licensing board to determine eligibility. Approved applicants take a multi-choice examination prepared and scored by the professional examination service of the American Public Health Association. This examination covers each of the major facets of a modern public health program, and thus insures that the newly licensed health administrator has a working knowledge of all essential programs. Licenses are valid indefinitely without re-examination. Although the licensing procedure was instituted in 1903,

it is only since 1950 that a college degree has been a requirement for admission to the examination.

Training of local health administrators has been considered a State Health Department responsibility since 1925, when the State Health Department, in cooperation with Rutgers, the State University, instituted special extension courses for health administrators and sanitarians. These courses have been expanded and are now given regularly.

According to Jesse B. Aronson, M.D., M.P.H.,[4] former director of Local Health Services in New Jersey, the effectiveness of a health administrator in influencing community action is directly related to the general status of health administrators. Full-time health administrators have been strongly represented on each committee appointed by the State Commissioner of Health to write new codes for adoption by local boards of health. The Committee that developed the legally enacted *Recommended Public Health Act* and *Minimum Standards of Performance for Local Health Departments* at the request of the State Commissioner of Health, was made up entirely of local health administrators.

As a result of the major role which non-medical health administrators played in 1959 in the establishment of the New Jersey Public Health Association, the first and third presidents of the Association were non-medical health

administrators. Within the last few years, a number of non-medical health administrators have been elected to fellowships in the Health Officers Section of the American Public Health Association.

Local health services in New Jersey present problems similar to those in other northeastern states in which local government rests primarily in the municipality. County government is generally limited in legal responsibilities and its services usually include little in public health. A large majority of the 568 municipalities in New Jersey have a population and a tax base that makes modern public health services, organized on the basis of individual municipalities, impractical. In spite of legislation permitting the formation of regional, district and county health departments, very little progress has been made in this direction. However, within the past few years, several county governments have employed licensed health officers together with appropriate staffs and have offered health department services to the municipalities by contract.

Aronson[5] has made the observation that many problems concerning local health administrators in New Jersey await solutions. He cites the need to obtain well-qualified health administrators to head local health departments in the large areas of New Jersey that now

have grossly inadequate services. Similar to other health administrators throughout the United States, he notes the need to establish relationships with hospitals, Visiting Nurse Association, and other health, social, and welfare agencies, so that effective programs for the control of chronic illness can be organized and maintained. He refers to the significant number of communities that still employ part-time health administrators and notes that persons who derive the major part of their earnings from other activities and who are not available for their health department responsibilities during regular working hours, cannot provide the necessary leadership in public health. For this reason, part-time health administrators do not participate in New Jersey State Department of Health activities.

To Aronson, raising the status of the local health administrator remains a major challenge - a problem which faces both medical and non-medical health administrators alike. Still another area of concern is recruitment and training of the non-medical health officer. In the normal evolution of a profession, a formal method of training is developed and becomes part of the pattern of the profession. For example, non-medical hospital administration became a well-established discipline when universities added graduate degree programs in the specialty.

In view of the tendency of some schools of public health to limit their graduate training in public health to physicians and to give precedence to the education of research personnel, attention must be directed to the need for trained health administrators, both medical and non-medical.

In the words of one health officer, when asked how he, as a young non-medical health administrator, looks to the future, he replied:

> *with unlimited optimism... the local health officer has the same basic responsibility to his community regardless of his background and education. He cannot limit his interest and vision to sanitation, vital statistics, and the traditional public health programs. He must broaden his horizon and serve as a leader and catalyst to the other professions and organizations in his community.*[6]

B. <u>The Public Health Administrator Today</u>

New Jersey, with its unique arrangement within its health structure contains two groups of bonafide public health administrators responsible for managing the health affairs of single and multiple communities. What distinguishes one group from the other is simply that one is licensed by the New Jersey State Department of Health as a consequence of a formal examination qualifing him as Health Officer, while the second (Executive Officer) has either failed to pass the Health Officer's licensing

examination, or has never taken it. In both instances, each group is accountable to a local Board of Health which is theoretically representative of a population base residing within a given geographic and political area and for which it provides a variety of health services as outlined in a document entitled *Minimum Standards of Performance for Local Health Departments*. This document has been offered as a guide by the Health Council, New Jersey State Department of Health.

While there are no limitations imposed upon "Health Officers" when seeking employment at the various levels of health administration, (i.e., population base, area of size or size of community to be served, etc.) such restrictions and limitations do exist for those without the license. For example, because it is mandated by State ordinance, Executive Officers are ineligible to fill top health administrative posts in communities serving a population base in excess of 10,000 people. This is particularly significant in New Jersey where most communities do exceed this minimum population base.

Given this general framework, how then can we perceive the variables of the public health administrator in New Jersey? In the following chapter the data from the questionnaire are presented.

CHAPTER IV - NOTES AND REFERENCES

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CHAPTER V

DATA AND ANALYSIS OF THE OCCUPATION

A. General Characteristics

Of the 156 public health administrators actively serving 568 local municipalities throughout the State of New Jersey during 1968-69, 118 (74%) were licensed by the State to serve in the capacity of "Health Officer." On the basis of the sample survey of 56 public health administrators (35% of the State total), consisting of 41 Health Officers (73%) and 15 Executive Officers (27%), we can draw the following profile:

Three-fourths of the public health administrators in New Jersey are licensed Health Officers. Irrespective of licensing fulfillment, two-thirds of those surveyed serve a single municipality, while one out of every four provides services to multiple municipalities ranging in number from two to six communities. Those serving large regions or county jurisdictions tend to be licensed administrators and constitute the remainder of the sample (9%), see Table 1.

TABLE 1: RESPONDENTS CLASSIFIED BY OCCUPATIONAL STATUS AND EXTENT OF SERVICE AREA

Extent of Service Area	Health Officers No.	%	Executive Officers No.	%
Single Municipality	26	63.4	11	73.3
Two or more Municipalities	15	36.6	4	26.7
TOTAL	41	100.0	15	100.0

P ($X^2 = 0.14$) > 0.5

As shown in Table 2, most administrators reported living in the area they serve.

TABLE 2: RESPONDENTS CLASSIFIED BY OCCUPATIONAL STATUS, LOCATION OF RESIDENCE, AND SERVICE AREA

Living in Service Area	Health Officers No.	%	Executive Officers No.	%
Yes	30	73.2	10	66.7
No	11	26.8	5	33.3
TOTAL	41	100.0	15	100.0

P ($X^2 = .020$)

When asked whether health administrators should live in the community where they work, slightly more than half answered yes (49% of the Health Officers and 57% of the Executive Officers). A major reason given for this response is the feeling that they can get to know the community better and as a consequence do a better job.

Another reason was the belief that it was important for health administrators to be a part of the community they serve in order to develop personal interest in the community, see Table 3.

TABLE 3: RESPONDENTS' REASONS WHY HEALTH ADMINISTRATORS SHOULD LIVE IN COMMUNITY SERVED

Reasons Given	Health Officers		Executive Officers	
	No.	%	No.	%
Get to know job better	4	11.8	2	16.7
Have personal interest	4	11.8	0	0
Must know community	10	29.4	5	41.7
Convenience	2	5.9	0	0
Important to be part of community	10	29.4	4	33.3
Other	4	11.8	1	8.3
TOTAL	34	100.0	12	100.0

Of those answering negatively to this question, 50% noted that the job should not be restricted to community citizens only since as a non-resident, the health administrator can be more objective in his job role. Table 4 reflects the reasons given.

TABLE 4: RESPONDENTS' REASONS WHY HEALTH ADMINISTRATORS SHOULD NOT LIVE IN COMMUNITY SERVED

Reasons Given	Health Officers No.	%	Executive Officers No.	%
Jobs should not be restricted to community citizens	1	6.3	0	0
Personal choice	1	6.3	1	16.7
Non-resident more objective	8	50.0	3	50.0
Several communities can be served	4	25.0	0	0
Job dedication important	2	12.4	1	16.7
So long as available	0	0	1	16.7
TOTAL	16	100.0	6	100.0

Despite the fact that 71.4% (Table 2) of the sample of administrators reported living in the area they serve, only 7.4% own their own residence, (Table 5).

TABLE 5: HEALTH ADMINISTRATORS RESPONSE TO OWNERSHIP OF RESIDENCE

Status	Health Officers No.	%	Executive Officers No.	%
Own	3	7.3	1	7.7
Rent	38	92.7	12	92.3
TOTAL	41	100.0	13	100.0

P (X^2 = .32)

Twenty-one percent of the total sample reported using their private residence as their business headquarters, (Table 6).

TABLE 6: HEALTH ADMINISTRATORS RESPONSE TO LOCATION OF BUSINESS HEADQUARTERS

Location	Health Officers No.	%	Executive Officers No.	%
Home	2	4.9	10	66.7
Office	39	95.1	5	33.3
TOTAL	41	100.0	15	100.0

There is an apparent lack of young administrators within the public health complex in New Jersey. For example, the group under 45 represents less than one-fourth of the total sample. The concentration of administrators lies in the age group 45-59 (48%). The age group 60 years and over contains 28% of all health administrators, (Table 7).

TABLE 7: AGE DISTRIBUTION OF RESPONDENTS

Age	Health Officers No.	%	Executive Officers No.	%
30 - 34	3	7.5	1	7.1
35 - 39	2	5.0	1	7.1
40 - 44	4	10.0	2	14.3
45 - 49	5	12.5	2	14.3
50 - 54	8	20.0	4	28.6
55 - 59	7	17.5	0	0
60 - 64	5	12.5	3	21.4
65 - 69	5	12.5	0	0
70+	1	2.5	1	7.1
TOTAL	40	100.0	14	100.0

As might be anticipated, one finds a high preponderance of male administrators (96% of the total). Also not surprising is the fact that 95% of all respondents are married.

Income, a major variable in determining an individual's status, offers certain insights into the profile. For example, 55% of those surveyed indicate that their annual income lies between $10,000 and $16,000 per year, while over 12% reported an income in excess of $19,000 per year. The latter group consists of Health Officers primarily those

who are physicians or who hold high administrative posts - in most cases, with larger health jurisdictions. Almost one-fourth of the total sample and 67% of the Executive Officers reported their yearly income as less than $10,000, (Table 8).

TABLE 8: ANNUAL INCOME OF RESPONDENTS

Income	Health Officers		Executive Officers	
	No.	%	No.	%
Under $10,000	3	7.5	10	66.7
$10,000-13,000	12	30.0	2	13.3
$13,000-16,000	15	37.5	1	6.7
$16,000-19,000	3	7.5	2	13.3
$19,000-22,000	3	7.5	0	0
$22,000-25,000	2	5.0	0	0
$25,000 +	2	5.0	0	0
TOTAL	40	100.0	15	100.0

The type(s) of licenses held and when they were issued are important considerations since prior to 1950 many licenses were issued under an existing "grandfather" clause.

Among Health Officers in the sample 43% were licensed prior to 1950, 12.5% hold medical licenses, and 30% are licensed Sanitarians. Among Executive Officers the license most prevalent is that of Sanitary Inspector (70%); 80% obtained this license after 1950 (Table 9).

TABLE 9: NUMBER OF HEALTH ADMINISTRATORS HOLDING PROFESSIONAL LICENSES BY THE TYPE OF LICENSE AND PERIOD FIRST OBTAINED

License Held	Health Officers		Executive Officers	
	Before 1950	After 1950	Before 1950	After 1950
Sanitary Inspector	14	11	3	13
Health Officer	19	23	0	0
Food & Drug Inspector	2	2	0	0
Plumbing Inspector	0	2	2	2
R.N.	0	0	0	1
Medical License	7	0	0	0
Water Supply & Sewer	0	1	0	2
Education	2	2	0	0
TOTAL	44	41	5	18

It is well recognized that educational achievement offers a major mechanism for fulfilling one's occupational aspirations. While one out of every 5 administrators in the sample population holds a doctorate degree (seven hold M.D. degrees) in some professional field (all Health Officers) it is interesting that these doctors indicate an occupation other than health administration as their primary occupation.

A further breakdown of the data shows that among the Health Officers sampled, 45% have a bachelor's degree, 21% a master's degree, and less than 11% never attended college. Among the Executive Officers 73% never attended college (Table 10).

TABLE 10: EDUCATIONAL ACHIEVEMENT OF RESPONDENTS

Educational Achievement	Health Officer No.	%	Executive Officer No.	%
High School or less	4	10.5	8	72.7
Some College	34	89.5	3	27.3
TOTAL	38	100.0	11	100.0

A major corrolary to educational achievement is the type of specialized training received in preparation for one's occupational role. The primary areas of training reported by all administrators were the following: (1) General Public Health; (2) Environmental Health; (3) Public Health Law and Administration. Of no surprise is the fact that most of the training received was provided either by Rutgers, The State University (50%), other colleges and universities in the State (22%), with the official state health agencies providing only 9% of the total training (Table 11).

TABLE 11: FREQUENCY OF SPECIALIZED TRAINING ACCORDING TO TYPE OF INSTITUTION AND AREA OF TRAINING FOR HEALTH ADMINISTRATORS

Type of Institution	Health Officers — Area of Training						Executive Officers — Area of Training					
	Gen'l P.H.	Environ. Health	P.H. Law & Admin.	Epidem.	Food & Drug	Other	Gen'l P.H.	Environ. Health	P.H. Law & Admin.	Epidem.	Food & Drug	Other
Rutgers	15	7	7	1	1	2	5	9	1	0	0	2
Other Colleges & Univ.	4	1	1	0	6	8	0	1	1	0	0	0
Hospitals	0	0	0	0	0	2	0	0	0	0	0	2
Fed.Health Agency	0	0	0	3	1	1	2	0	0	1	0	0
Voluntary Health Agen.	1	0	0	0	0	1	0	0	0	0	0	0
Official Health Agen.	3	2	0	0	0	2	0	1	0	0	0	1
Military Estab.	1	1	0	0	0	3	0	0	0	0	0	0
TOTAL	24	11	8	4	8	19	7	11	2	1	0	5

Worthy of mention is the fact that over 64% of the participants in specialized training programs were more than 9 years ago, while about 20% were within the last 5 years (Table 12).

TABLE 12: FREQUENCY ACCORDING TO YEARS SINCE SPECIALIZED TRAINING WAS OBTAINED BY TYPE OF INSTITUTION FOR HEALTH ADMINISTRATORS

Type of Institution	Health Officers					Executive Officers				
	0-2	2-5	5-9	9+	Total	0-2	2-5	5-9	9+	Total
Rutgers	1	3	5	17	24	1	1	3	9	14
Other Col. & Univ.	0	3	2	10	15	0	1	0	1	2
Hospitals	0	0	0	2	2	0	0	0	2	2
Fed.Hlth. Agency	0	2	1	1	4	0	1	0	2	3
Vol.Hlth. Agency	0	0	0	1	1	0	0	1	0	1
Off'l Hlth. Agency	0	1	1	1	3	0	2	1	0	3
Military Estab.	0	0	0	5	5	0	0	0	0	0
TOTALS	1	9	7	37	54	1	5	5	14	25

B. Work Experience

A major consideration in the construction of an occupational profile is a person's work experience. Of importance here is the experiences and tenure acquired in

the field in general, and specifically in the present occupational role.

Twenty-five percent of the health administrators surveyed have been employed in public health work for 20-24 years, 18% have been employed from 2-9 years, and 15% from 10-14 years. The greatest proportion, (over 27%) have been in the public health field over 30 years. Over 80% of those surveyed have been in the field for 10 years or more (Table 13).

TABLE 13: YEARS HEALTH ADMINISTRATORS EMPLOYED IN PUBLIC HEALTH

Years Employed	Health Officers No.	%	Executive Officers No.	%
Under 10	6	14.6	4	28.6
Over 10	35	85.4	10	71.4
TOTAL	41	100.0	14	100.0

$P\ (X^2 = .59) > .05$

When we consider the administrators' present positions, over 27% have held the position for over 30 years. The remainder of the sample was distributed as follows: 10-14 years, 14.5%, 15-19 years, and 20-24 years, 12.7% each. In general, slightly less than 50% of those sampled have been employed in present position for over 10 years (Table 14).

TABLE 14: YEARS HEALTH ADMINISTRATORS HAVE BEEN EMPLOYED IN PRESENT POSITION

Years Employed	Health Officers No.	%	Executive Officers No.	%
Under 10	22	53.7	6	42.9
Over 10	19	46.3	8	57.1
TOTAL	41	100.0	14	100.0

P ($X^2 = 0.15$) > .05

When we look into the previous public health positions held by the administrators sampled, we find a broad range including, Executive Officer, Sanitary Inspector, Plumbing Inspector, medical services and other related jobs. However, the position most frequently noted is that of Sanitary Inspector, reported 35% of the time. When a time variable is considered on previously held positions, we find that most were held for long periods of time, with 24% being in these positions for less than 4 years, 28% from 5-10 years, and more than half (48%) over 10 years (Table 15).

TABLE 15: PUBLIC HEALTH POSITIONS PREVIOUSLY HELD BY HEALTH ADMINISTRATORS BY LENGTH OF SERVICE

	Health Officers								Executive Officers							
Length of Service	Health Officer	Executive Officer	Sanitary Inspector	Plumbing Inspector	Medical Service	U.S.P.H.S.	Other	Total	Health Officer	Executive Officer	Sanitary Inspector	Plumbing Inspector	Medical Service	U.S.P.H.S.	Other	Total
Less than 2	1	1	2	0	1	0	3	8	0	0	0	0	0	0	0	0
2-4	5	0	4	0	1	0	1	11	0	0	0	0	0	0	0	0
5-10	5	0	7	1	0	0	3	16	0	0	2	2	0	0	1	5
10-20	1	1	8	0	1	2	1	14	0	0	3	1	0	1	0	5
20+	3	0	1	0	2	2	8	16	0	1	1	0	0	0	1	3
TOTAL	15	2	22	1	5	3	16	65	0	1	6	3	0	1	2	13

Ninety percent of the Health Officers indicated that their position is full time in contrast to only 27% of the Executive Officers (Table 16).

TABLE 16: STATUS OF PRESENT POSITION OF HEALTH ADMINISTRATORS

Status	Health Officers No.	Health Officers %	Executive Officers No.	Executive Officers %
Full Time	34	89.5	4	26.7
Part Time	4	10.5	11	73.3
TOTAL	38	100.0	15	100.0

Those whose positions are part-time indicate that their other job involvements are primarily in related health fields, with 15% indicating that they have held these positions for less than 5 years (Table 17).

TABLE 17: OTHER POSITIONS CURRENTLY HELD BY HEALTH ADMINISTRATORS BY LENGTH OF TIME & TYPE OF POSITION

	Health Officers							Executive Officers						
Length of time	Plumbing Insp.	Med. Service	Genl Municipal	Academic	Industrial	Other	Total	Plumbing Insp.	Med. Service	Genl Municipal	Academic	Industrial	Other	Total
Less than 5 years	0	0	0	1	1	1	3	0	0	1	0	0	0	1
5-10	0	0	0	0	0	1	1	1	0	1	0	0	0	2
10-15	0	0	1	0	0	0	1	0	0	0	0	0	2	2
15-20	0	0	1	0	0	1	2	0	0	1	0	0	0	1
20-25	0	0	0	0	0	0	0	0	0	0	0	0	1	1
25-30	0	0	1	0	0	0	1	0	0	0	0	0	0	0
30 +	0	1	0	0	1	1	3	1	0	0	0	4	3	8
TOTAL	0	1	3	1	2	4	11	2	0	3	0	4	6	15

In response to the question as to "which position is most important," the major response (22%) indicate that they feel all their positions are of equal importance, while 26%

indicate another public health position is most important. Nine percent indicated that their part time position in industry was most important. Among the Health Officers, 64% indicated that their Health Officer position was most important (Table 18).

TABLE 18: COMPARATIVE IMPORTANCE OF MULTIPLE POSITIONS OF HEALTH ADMINISTRATORS

	Health Officers		Executive Officers	
Position	No.	%	No.	%
Sanitary Inspector	0	0	3	25.0
Equally Important	2	18.2	3	25.0
Industrial	0	0	2	16.7
Plumbing Inspector	0	0	1	8.3
P.H.(Gen'l)	2	18.2	0	0
Executive Offices	0	0	2	16.7
Full Time Positions	7	63.6	1	8.3
TOTAL	11	100.0	12	100.0

In response to the question "in what ways is your present position important to you," 27% of the administrators sampled indicated that the job provided a good income, while 40% found it to be a gratifying job. Only 10% gave security or tenure as a reason. Twenty-three

percent indicated that their present position was important because it provided them with an opportunity to direct public health programs as well as work with other community health agencies. Surprisingly, none of these sampled suggested that their positions gave them any degree of status (Table 19).

TABLE 19: REASONS WHY PRESENT POSITION IS IMPORTANT TO HEALTH ADMINISTRATORS

	Health Officers		Executive Officers	
Reasons	No.	%	No.	%
Good Income	2	15.3	6	35.2
Gratifying Job	3	23.1	3	17.6
Challenge	3	23.1	2	11.8
Opportunity to Direct & Supervise P.H. Prog.	3	23.1	2	11.8
Opportunity to Work w/Community Agency	1	7.7	0	0
Enjoy Security of Tenure	1	7.7	2	11.8
Keep Abreast of P.H. Problems	0	0	1	5.9
Enjoy Administrative Work	0	0	1	5.9
TOTAL	13	100.0	17	100.0

In terms of their relationship with a teaching institution, only 15% of the Health Officers and none of the Executive Officers have any professional involvement with a teaching institution (Table 20).

TABLE 20: POSITION OR RELATIONSHIP WITH TEACHING INSTITUTION AS REPORTED BY HEALTH ADMINISTRATORS

	Health Officers		Executive Officers	
Position	No.	%	No.	%
Yes	6	15.0	0	0
No	34	85.0	13	100.0
TOTAL	40	100.0	13	100.0

Fisher's Exact Test for 2x2 tables; p = .17 (ns)

Those Health Officers indicating a relationship with a teaching institution reported their academic rank as instructor (50%) and lecturer (50%) (Table 21).

TABLE 21: ACADEMIC RANK OF HEALTH OFFICERS

Rank	Number	Percent
Instructor	3	50.0
Lecturer	3	50.0
TOTAL	6	100.0

One half of those holding academic rank are affiliated with Rutgers University (Table 22).

TABLE 22: INSTITUTION WHERE ACADEMIC RANK IS HELD BY HEALTH ADMINISTRATORS

	Health Officers	
Institution	No.	%
Rutgers University	3	50.0
Other	3	50.0
TOTALS	6	100.0

Two-thirds of those with academic rank (Instructor or Lecturer) are directly involved in teaching (Table 23).

TABLE 23: DUTIES OF HEALTH ADMINISTRATOR AT ACADEMIC INSTITUTION

	Health Officers	
Duties	No.	%
Teaching	4	66.7
Other	2	33.3
TOTAL	6	100.0

Professional papers prepared for either presentation at meetings or published in professional journals, are mostly in the area of environmental sanitation (22%), while 9.4% are in public health administration (Table 24).

TABLE 24: TYPE OF PROFESSIONAL PAPERS READ AND/OR PUBLISHED BY HEALTH ADMINISTRATORS

	Health Officers		Executive Officers	
Type of Paper	No.	%	No.	%
Environmental	4	17.4	0	0
Sanitation	2	8.7	1	11.1
Administration	3	13.0	0	0
Medical	2	8.7	0	0
Other	2	8.7	0	0
None	10	43.5	8	88.9
TOTAL	23	100.0	9	100.0

Where papers have either been read and/or published, most were done over five years ago (77%), while the remainder (23%) were submitted between 5-9 years ago (Table 25).

TABLE 25: WHEN PAPER WAS READ AND/OR PUBLISHED BY HEALTH ADMINISTRATOR

	Health Officers		Executive Officers	
Time Read	No.	%	No.	%
Over 2 yrs ago	4	19.0	1	12.5
3-5 yrs ago	5	23.8	0	0
5-9 yrs ago	3	14.3	0	0
None	9	42.9	7	87.5
TOTAL	21	100.0	8	100.0

Most papers were presented at health conferences although a number were given at professional meetings with the remainder given at general community meetings. In all instances, most of the papers were given by Health Officers as opposed to Executive Officers (Table 26).

TABLE 26: WHERE PAPER WAS READ AND/OR PUBLISHED BY HEALTH ADMINISTRATOR

	Health Officers		Executive Officers	
Place Read/ Published	No.	%	No.	%
Health Conference	6	26.1	0	0
Medical Society	1	4.3	0	0
NJ State Dept. of Health	1	4.3	0	0
NJ Health Off. Assn.	2	8.7	0	0
College or University	0	0	1	12.5
Other	4	17.4	0	0
None	9	39.2	7	87.5
TOTAL	23	100.0	8	100.0

Where papers were presented, the group composition tended to be general health personnel (sanitarians, plumbers, etc.) 50%, health administrators 17% and physicians 8%. The remainder constituted a variety of audiences outside of the realm of public health (Table 27).

TABLE 27: AUDIENCE COMPOSITION FOR PAPERS READ AND/OR PUBLISHED BY HEALTH ADMINISTRATORS

	Health Officers		Executive Officers	
Audience	No.	%	No.	%
Health Admin.	2	18.2	0	0
Physicians	1	9.1	0	0
General Health Personnel	5	45.5	0	0
Sanitarians	0	0	1	100.0
Other	3	27.3	0	0
TOTAL	11	100.0	1	100.0

C. Recruitment

How people are attracted to a particular type of work, and what makes them decide on a specific occupational career are important questions. In attempting to understand the motivating forces which led health administrators to choose public health as a field of interest and as an occupation, we must examine the responses given to several pertinent questions. The reasons provide interesting insights toward understanding their career choice as an occupational group.

Interest in the medical field (26.3%), perhaps reflecting aspirations for a medical career, the influence of a father who previously served in a health administrative capacity (20%), and the influence of another public health

worker or friend (21%) are major reasons given for choosing public health administration as an occupational career. Of equal significance is the fact that only 1% noted that a position in public health was available when they needed a job (Table 28).

TABLE 28: SOURCES OF INTEREST IN PUBLIC HEALTH WORK AS REPORTED BY HEALTH ADMINISTRATORS

	Health Officers		Executive Officers	
Sources	No.	%	No.	%
Thru P.H. Worker	11	14.9	1	4.0
Thru Friend	9	12.2	0	0
Interest in Public Service	2	2.7	2	8.0
Exposure	3	4.1	1	4.0
Public Appointment	12	16.2	1	4.0
During Military Service	6	8.1	4	16.0
Interest in Medical Field	17	23.0	9	36.0
Father was Health Officer	13	17.6	7	28.0
Position Available	1	1.4	0	0
TOTAL	74	100.0	25	100.0

The major reason (38.4%) given for deciding on the present occupation was an interest in public health and/or administration. Possible career advancement and challenges which the field offers were noted by 23% of the respondents. Only 9% of the sample noted financial remuneration as their reason. A significant number (20%) noted that availability of the position was the prime basis for their decision (Table 29).

TABLE 29: REASONS FOR DECIDING TO BECOME A HEALTH ADMINISTRATOR

	Health Officer		Executive Officer	
Reasons	No.	%	No.	%
Interest in Adminis.	11	14.9	1	4.0
Salary	9	12.2	0	0
Assigned to Position	2	2.7	2	8.0
Military Exp.	3	4.1	1	4.0
Career Advancement	12	16.2	1	4.0
Challenge	6	8.1	4	16.0
Interest in P.H.	17	23.0	9	36.0
Position Available	13	17.6	7	28.0
Graduate Training	1	1.4	0	0
TOTAL	74	100.0	25	100.0

When asked if there were "other factors" influencing their decision, job satisfaction was reported by 17.6%, while money and upward mobility were factors noted by 16% (Table 30).

TABLE 30: OTHER FACTORS INFLUENCING DECISION TO BE A HEALTH ADMINISTRATOR

	Health Officers		Executive Officers	
Factors	No.	%	No.	%
Need for Leadership	3	6.3	0	0
Interest	7	14.6	3	15.0
Challenge	4	8.3	2	10.0
Open to Women	1	2.1	0	0
Job Satisfaction	8	16.7	4	20.0
Money	4	8.3	2	10.0
Upward Mobility	5	10.4	0	0
Influence of Others	3	6.3	3	15.0
Other	13	27.1	6	30.0
TOTAL	48	100.0	20	100.0

D. Training

Recognizing that many occupational careers often require specific training and education as prerequisites

for a position, questions concerning training and the type of training required were asked. Ninety-two per cent of the administrators surveyed indicated that some training was required for their present position (Table 31).

TABLE 31: RESPONSE OF HEALTH ADMINISTRATORS TO QUESTION, WAS THERE ANY TRAINING REQUIRED FOR POSITION?

	Health Officers		Executive Officers	
Training Required	No.	%	No.	%
Yes	34	89.5	11	100.0
No	4	10.5	0	0
TOTAL	38	100.0	11	100.0

While training was required, 30.4% reported that the training was in environmental sciences, while only 4.3% noted administration as a required area. Sixty-five per cent offered a wide range of subjects including public health, law, sanitation, health education, sewage disposal, etc (Table 32).

TABLE 32: TYPE OF TRAINING REQUIRED OF HEALTH ADMINISTRATORS

Type of Training	Health Officers		Executive Officers	
	No.	%	No.	%
Environmental	7	20.6	7	58.3
Administrative	2	5.9	0	0
Health Education	1	2.9	0	0
Other	24	70.6	5	41.7
TOTAL	34	100.0	12	100.0

Not surprising is the fact that almost 60% of the training was conducted at Rutgers University, while of great surprise is the fact that less than 10% of the training was conducted at the New Jersey State Department of Health Offices. In less than 5% of the sample the local board of health was reported as the training center (Table 33).

TABLE 33: SOURCE OF TRAINING OF HEALTH ADMINISTRATORS

Source of Training	Health Officers		Executive Officers	
	No.	%	No.	%
Rutgers University	14	48.3	11	84.6
NJ State Dept of Health	3	10.3	1	7.7
Local Board of Health	2	6.9	0	0
Other	10	34.5	1	7.7
TOTAL	29	100.0	13	100.0

When we consider the agent sponsoring the training, we find that the responses are closely related to those given in the previous question. Almost 54% was sponsored by Rutgers, while approximately 20% was sponsored by the State Department of Health. Only in 5% of the cases was the Local Board of Health the sponsor (Table 54).

TABLE 34: AGENT SPONSORING TRAINING FOR ADMINISTRATORS

	Health Officers		Executive Officers	
Sponsor	No.	%	No.	%
Rutgers University	12	41.4	10	83.3
NJ State Dept of Health	6	20.7	2	16.7
Local Board of Health	2	6.9	0	0
Other	9	31.0	0	0
TOTAL	29	100.0	12	100.0

For the most part the training lasted over a period of from 3-6 months (22%), while 16% reported the length of training as lasting from 6 months to one year. In 19% of the cases the training ranged from 2-8 weeks (Table 35).

TABLE 35: LENGTH OF TRAINING OF HEALTH ADMINISTRATORS

	Health Officers		Executive Officers	
Length of Training	No.	%	No.	%
Under 6 mos	8	30.8	8	72.7
More than 6 mos	18	69.2	3	27.3
TOTAL	26	100.0	11	100.0

$P\ (X^2 = 3.97) = .05$

Despite the variety of training programs offered and the different ranges in length of training, most administrators (76%) feel that the training received for their present positions was adequate. Of these, less than 2% indicated that although they felt the training was adequate at the time they received it, they found it had little current value (Table 36).

TABLE 36: RESPONSES OF HEALTH ADMINISTRATORS TO QUESTION, WAS TRAINING FOR JOB ADEQUATE?

	Health Officers		Executive Officers	
	No.	%	No.	%
Yes	31	77.5	11	73.3
No	9	22.5	4	26.7
TOTAL	40	100.0	15	100.0

Most occupational groups tend to set up provisions for the recruitment of future members. In response to the question "how should health administrators be recurited?", the predominant response was "through grants and scholarships" (34%). Better than 20% noted that one's experience and interest in the field should be the primary consideration, while previous success in other jobs was stated by 17.6% of

the sample. Only 2.7% felt that the basis for recruitment should be the passing of an examination, while 2.7% felt that recruitment should be a prime responsibility of the health workers themselves and the various health departments, both of which should have a vested interest in the recruitment process (Table 37).

TABLE 37: RESPONSE TO QUESTION, HOW SHOULD HEALTH ADMINISTRATORS BE RECRUITED?

	Health Officers		Executive Officers	
Recruitment	No.	%	No.	%
Grants and Scholarships	18	34.6	7	31.8
Examination	2	3.8	0	0
By Health Workers and Departments	2	3.8	0	0
Interest	3	5.8	3	13.6
Experience	8	15.4	1	4.6
Previous Success	11	21.2	2	9.1
Other	8	15.4	9	40.9
TOTAL	52	100.0	22	100.0

The most consistent answer on the definition of a successful health administrator was that he should have a well rounded "administrative background" (20%). Other definitions were based on understanding the job (14.4%),

handling responsibility (13.6%), dedication to the field of public health, (10.4%), possession of a strong public health orientation and commitment (10.4%), be progressive (9.6%), influential (4.8%). The feeling that a successful health administrator is one with "high professional status" was reported by less than 1% of the sample (Table 38).

TABLE 38: RESPONDENTS' DEFINITIONS OF A SUCCESSFUL ADMINISTRATOR

	Health Officers		Executive Officers	
Definitions	No.	%	No.	%
Dedication	10	10.8	3	9.4
Progressive	8	8.6	4	12.5
P.H. Oriented	10	10.8	3	9.4
Understanding	13	14.0	5	15.6
Assumes Responsibility	13	14.0	4	12.5
Has Influence	5	5.4	1	3.1
Has Status	1	1.1	0	0
Understands Adminis.	18	19.4	7	21.9
Other	15	16.1	5	15.6
TOTAL	93	100.0	32	100.0

An extreme question was posed in terms of "what are the reasons leading to failure as a health administrator?" The major responses were: inability on the part of health administrators to communicate effectively (26%), inadequate training and experience as administrators (24%), active involvement in politics (17%). Other reasons were poor work habits (10%), lack of leadership (7%), personality, and low salary and budget (.06% each), (Table 39).

TABLE 39: OBSTACLES LEADING TO FAILURE AS HEALTH ADMINISTRATOR

	Health Officer		Executive Officer	
Obstacles	No.	%	No.	%
Poor Communication	22	26.2	7	25.0
Politics	14	16.7	5	17.9
Inadequate Training and Experience	19	22.6	8	28.6
Poor Work Habits	8	9.5	4	14.3
Low Salary & Budget	6	7.1	1	3.6
Inadequate Laws & Enforcement	2	2.4	1	3.6
Lack of Leadership	7	8.3	1	3.6
Personality	6	7.1	1	3.6
TOTAL	84	100.0	28	100.0

Eighty-nine per cent of the sample indicated having participated in some type of formal public health training since becoming a health administrator. However, the extent, type of training or recentness was not indicated (Table 40).

TABLE 40: FORMAL PUBLIC HEALTH TRAINING SINCE BECOMING A HEALTH ADMINISTRATOR

	Health Officers		Executive Officers	
Training	No.	%	No.	%
Yes	36	90.0	12	85.7
No	4	10.0	2	14.3
TOTALS	40	100.0	14	100.0

P (x^2 = .003)

One question asked Executive Officers was aimed at determining what, if any, were their personal aspirations for becoming licensed as Health Officers. This response might well be because many may feel either that they are not likely to pass the examination if they took it, or they cannot meet the State prerequisites for admission to the examination. This response is of interest since any significant changes in the occupational status of Executive Officers as health administrators can only be achieved by becoming Health Officers.

TABLE 41: RESPONSES OF EXECUTIVE OFFICERS CONCERNING ASPIRATIONS TO BECOME A HEALTH OFFICER

Aspiration	Executive Officers No.	%
Yes	3	21.4
No	11	78.6
TOTAL	14	100.0

The following reasons which were given for not aspiring to the level of the licensed Health Officer are of interest. One half of the Executive Officers responding to this question note that the present requirements for achieving Health Officer status are too high and discriminating. Thirty percent indicate satisfaction with their present position (possibly because it provided them flexibility to "moonlight") and 10% plan to retire in the very near future (Table 42).

TABLE 42: REASONS GIVEN BY EXECUTIVE OFFICERS FOR NOT ASPIRING TO BE A HEALTH OFFICER

Reasons	Executive Officers No.	%
Requirements too High	2	33.3
Requirements Discriminate	0	0
Present Title of Health Officer	1	16.7
Not Necessary	2	33.3
Retiring	1	16.7
TOTAL	6	100.0

E. Community Setting

How public health administrators are viewed in the community, and the extent to which their status undergoes changes is central to their professional growth. Almost 75% of the health administrators feel that their place in the community has changed. An effort was made to determine in what respect it has changed. Almost 35% indicated that the health administrator's place has changed because he is now beginning to get his due recognition as the "health administrator." His growing involvement with other health agencies has also brought about significant changes in the administrator's place in the community (10%). Twenty-eight per cent indicate that his place has changed due to the increase in public health needs. Of less significance, accounting for 1.3% of the total sample were the following: (1) lack of qualified personnel, (2) image of the health administrator has declined, and (3) the recent trend toward the upgrading of public health codes. Only 2.7% account for the trend toward reorganizing health municipalities as a factor in bringing about a change, while the same percentage indicates that the decline in communicable disease accounts for this change (Table 42A).

TABLE 42A: EXPLANATIONS FOR CHANGES IN HEALTH ADMINISTRATOR'S POSITION

	Health Officers		Executive Officers	
Explanation	No.	%	No.	%
Increased P.H. Needs	15	26.8	6	31.6
Lack of Qualified Personnel	1	1.8	0	0
Image of Health Admin. Has Declined	1	1.8	0	0
Recognition of Health Adminis.	19	33.9	7	36.8
Reorganization of Municipality	1	1.8	1	5.3
Involvement with Other Health Agencies	6	10.7	2	10.5
Less Communicable Disease	2	3.6	0	0
Upgrading of Codes	0	0	1	5.3
Other	11	19.6	2	10.5
TOTAL	56	100.0	19	100.0

When taken from the other extreme, that is, why the health administrator's position has not changed in the community, the responses are interesting. Almost 16% indicate that there has been no need for change in the administrator's place in the community. The following three variables each account for 10.5% of the

total responses concerning why the position has not changed: (1) the administrator has failed to increase his knowledge of health administrator functions, (2) the health administrator still remains an untrained person in his profession, and (3) the role of the health administrator in the field of public health and the community at large lacks the proper recognition. In addition, 5.3% indicate that no change has taken place because funds for public health are still lacking, and another 5.3% indicate that public health legislation has not changed sufficiently to bring about changes in the health administrator's place in the community (Table 43).

TABLE 43: EXPLANATIONS FOR LACK OF CHANGE IN HEALTH ADMINISTRATOR'S POSITION

Explanation	Health Officers		Executive Officers	
	No.	%	No.	%
Lack of Knowledge of Health Admin.Function	1	7.7	1	16.7
No Need for Change	2	15.4	1	16.7
Lack of Professional Personnel	2	15.4	0	0
Lack of Recognition	1	7.7	1	16.7
Lack of Funds	1	7.7	0	0
Lack of Legislation	1	7.7	0	0
Other	5	38.5	3	50.0
TOTAL	13	100.0	6	100.0

A question was posed concerning the health administrator's future role. Most of the administrators (92.5%) believe there will be a change in the role in the future (Table 44).

TABLE 44: WILL THERE BE A CHANGE IN HEALTH ADMINISTRATOR'S ROLE?

	Health Officers		Executive Officers	
Future Changes	No.	%	No.	%
Yes	37	90.2	12	100.0
No	4	9.8	0	-
Total	41	100.0	12	100.0

The major changes anticipated by those surveyed are: (1) a major trend toward comprehensive health planning which will affect the health administrator's role directly (35.4%), (2) an increasing desire for professional recognition and more professionalism (22.8%), (3) an increasing population that will bring about increasing need for health services (12.7%), (4) larger health departments serving a greater number of municipalities, (11.4%), (5) increased educational requirements for the licensing of Health Officers, (6.3%) and (6) the possibility of obtaining more state financial aid (6.3%). The possibility of better salaries was considered by only 3.8% of the sample (Table 45).

TABLE 45: WHAT CHANGES CAN BE ANTICIPATED IN THE FUTURE

	Health Officers		Executive Officers	
Future Changes	No.	%	No.	%
Increased Educational Requirements (Lic.)	3	5.1	2	10.0
Larger Health Depts.	6	10.2	3	15.0
More Professionalism	11	18.6	3	15.0
Less Politics	1	1.7	0	0
Better Salaries	3	5.1	0	0
Comp. Health Planning	22	37.3	6	30.0
Population Increase	6	10.2	4	20.0
More State Aid	4	6.8	1	5.0
More Recognition of Health Administrator	3	5.1	1	5.0
TOTAL	59	100.0	20	100.0

F. Membership

The type of association membership one holds is often determined by one's occupation and serves as an index of professional aspiration. On the basis of the survey it is apparent that Health Officers are members.

As might be expected the most popular professional organizations among both groups is the New Jersey Health Officer's Association with one-third of the Health Officers and one-third of the Executive Officers serving as members.

Among Health Officers, membership in the American Public Health Association was the second most important professional membership with 23% of the administrators holding membership in this association. The New Jersey Public Health Association and the County Health Officer's Association were listed as the third single most popular professional association among Health Officers. Also, 16% of the Health Officers sampled hold membership in a variety of related health and medical associations, while less than 5% reported membership in their County Medical Society. This is not surprising since a very small number of Health Officers are actually physicians, (mostly part time).

Executive Officers are far less active as participants of professional organizations. One out of every 4 reported membership in the New Jersey Health Officer's Association, and the same ratio reported membership in their County Health Officer's Association. Only 8.3% reported membership in the American Public Health

Association. Of interest is the fact that while 25% of those reporting hold membership in various related health and medical societies, i.e., sanitary, environmental, education, air pollution societies, etc., a significant per cent (16.7%) are active in a number of non-health and medical societies, such as citizen's committees, firemen's associations, etc. This participation in the non-health and medical societies for Executive Officers is high compared to 1.2% for Health Officers (Table 46).

TABLE 46: MEMBERSHIP IN PROFESSIONAL ORGANIZATIONS

	Health Officers		Executive Officers	
Membership	No.	%	No.	%
County Med. Society	4	4.9	0	0
NJ Health Off. Association	27	32.9	3	25.0
NJ Public Health Association	9	11.0	0	0
American Public Health Assoc.	19	23.2	1	8.3
County Health Off. Assn.	9	11.0	3	25.0
Other Health/Med. Soc.	13	15.9	3	25.0
Other Non-Health/ Medical Society	1	1.2	2	16.7
TOTAL	82	100.0	12	100.0

It appears clear on the basis of professional affiliation that Health Officers tend to feel either a greater need to belong to those associations which constitute a vital part of their occupational life (perhaps also reflecting their own image in a professional role) than Executive Officers who participate more in non-health and medical associations. Perhaps the best way to understand why some Health Administrators participate in professional organizations more than others might be explained in the discussion.

While the response to the following question was small in number (31 Health Officers and 3 Executive Officers) these responses offer some guides concerning their participation. Among both groups (Health Officers and Executive Officers) the most important reason for joining a professional association was their feeling that it is "professional to do so" (68% Health Officers, and 67% Executive Officers). Other reasons given by Health Officers were to gain more knowledge about the field (11%) and to make personal contacts (7%) (Table 47).

TABLE 47: REASONS FOR JOINING A PROFESSIONAL ASSOCIATION

	Health Officers		Executive Officers	
Reasons	No.	%	No.	%
Personal Contact	2	7.1	0	0
Information	1	3.6	1	33.3
Material Interest	1	3.6	0	0
Knowledge	3	10.7	0	0
Business	1	3.6	0	0
Professionalism	19	67.9	2	66.7
Other	1	3.6	0	0
TOTAL	28	100.0	3	100.0

Of the 40 administrators (33 Health Officers and 7 Executive Officers) responding to the question "are you still a member of a professional association" -- all 40 answered in the affirmative. When questioned on their attendance at meeting (a much more significant index than membership for assessing active involvement) 47% of the Health Officers and 50% of the Executive Officers noted that they attended over 75% of the meetings held. Among Health Officers only 25% attend less than 1/4 of the meetings, while 13% attent between 1/4 and 1/2 of the time (Table 48).

TABLE 48: RESPONSES TO ATTENDANCE AT PROFESSIONAL MEETINGS

Percent of Meetings Attended	Health Officers No.	Health Officers %	Executive Officers No.	Executive Officers %
Less than 50%	7	23.3	2	50.0
More than 50%	23	76.7	2	50.0
TOTAL	30	100.0	4	100.0

Of the six Health Officers serving as officers of professional associations, five are presidents. Only one Executive Officer holds an office position, that of vice-president (Table 49).

TABLE 49: OFFICES HELD IN PROFESSIONAL ASSOCIATIONS

Office	Health Officers No.	Health Officers %	Executive Officers No.	Executive Officers %
President	5	71.4	0	0
Vice President	0	0	1	50.0
Secretary	1	14.3	0	0
None	1	14.3	1	50.0
TOTAL	7	100.0	2	100.0

In addition to professional associations, many health administrators are involved in the full range of existing diversified associations, i.e., civic, fraternal, church related, and a variety of other community groups.

The most prevalent type of civic organization in which membership was reported was Voluntary Community Agencies (mostly in the health field). This is not surprising since as the primary health resource person in the community many voluntary health agencies seek the participation of public health administrators, particularly as board members. Although only 8 Executive Officers responded to this question, two indicated involvement with county disaster organizations; one Health Officer reported involvement with ethnic groups (Table 50).

TABLE 50: MEMBERSHIP IN CIVIC ORGANIZATIONS

Type of Organization	Health Officers No.	%	Executive Officers No.	%
County Disaster	2	8.0	2	25.0
Political Assoc.	2	8.0	1	12.5
Municipal Council and Boards	2	8.0	0	0
Volunteer Commun. & Welfare Agencies	11	44.0	4	50.0
Ethnic Groups	1	4.0	0	0
Other	7	28.0	1	12.5
TOTAL	25	100.0	8	100.0

In general, 26.3% of the respondents have joined civic organizations because of the "material interest" factor. Only 16% indicate joining civic organizations for professional reasons (none of these were Executive Officers). Another 16% indicate the opportunity for making contacts (again none were Executive Officers (Table 51).

TABLE 51: REASONS FOR JOINING CIVIC ORGANIZATIONS

	Health Officers		Executive Officers	
Reasons	No.	%	No.	%
Personal Contact	3	20.0	0	0
Information	2	13.3	0	0
Material Interest	1	6.7	4	100.0
Professionalism	3	20.0	0	0
Other	6	40.0	0	0
TOTAL	15	100.0	4	100.0

Eighty-seven percent of the administrators are still members of a civic organization, (Table 52) and 50% attend at least 3/4 of the meetings held, while 25% attend not more than 1/4 of the meetings. Between 1/4 and 1/2 of the meetings are attended by 21% of the administrators and another 21% attend from 50 to 75% of the civic meetings held (Table 53). Forty-seven per cent attend between 75% and 100% of civic meetings held.

TABLE 52: CURRENT MEMBERSHIP OF RESPONDENTS IN CIVIC ORGANIZATION

	Health Officers		Executive Officers	
Current Membership	No.	%	No.	%
Yes	16	88.9	5	83.3
No	2	11.1	1	16.7
TOTAL	18	100.0	6	100.0

TABLE 53: FREQUENCY OF ATTENDANCE AT CIVIC MEETINGS

	Health Officers		Executive Officers	
Frequency of Attendance (Percentage)	No.	%	No.	%
0 - 25	2	13.3	0	0
26 - 50	3	20.0	1	25.0
51 - 75	3	20.0	1	25.0
76 - 100	7	46.7	2	50.0
TOTAL	15	100.0	4	100.0

Fraternal associations, oftentime inclined to favor professional men, represent one of the main types of associations in which health administrators are involved. The Elks appears to be the most popular fraternal association among Health Officers and Executive Officers representing 18.5% of their total participation. Second in order of preference are the Knights of Colum-

bus (14.8%) followed by the Masonic Order (7.4%). Aside from the major fraternal orders, the remainder of the sample is dispersed over a large number of fraternal groups, primarily of a local or regional nature. (Table 54)

TABLE 54: TYPE OF FRATERNAL ASSOCIATION MEMBERSHIP

	Health Officers		Executive Officers	
Fraternal Organization	No.	%	No.	%
Knights of Columbus	3	15.0	1	14.3
Mason	1	5.0	1	14.3
Elks	4	20.0	1	14.3
V.F.W.	1	5.0	0	0
Other	11	55.0	4	57.1
TOTAL	20	100.0	7	100.0

Many reported joining a fraternal association in order to make personal contacts (29.4%). Whether this can be interpreted to mean that they join a fraternal association to advance themselves, or to advance the health department they represent is not clear. Only 6% joined for professional reasons. (Table 55)

TABLE 55: REASON FOR JOINING FRATERNAL ASSOCIATION

	Health Officers		Executive Officers	
Reasons Given	No.	%	No.	%
Personal Contact	4	26.7	1	50.0
Information	1	6.7	0	0
Material Interest	2	13.3	0	0
Professionalism	1	6.7	0	0
Other	7	46.7	1	50.0
TOTAL	15	100.0	2	100.0

Almost 96% of those reporting are still members of a fraternal association, (Table 56) of whom 1/3 attend less than 25% of the meetings held and 39% attend at least 76% of the meetings. (Table 57)

TABLE 56: CURRENT MEMBERSHIP IN FRATERNAL ASSOCIATION

	Health Officers		Executive Officers	
Current Member	No.	%	No.	%
Yes	17	100.0	4	80.0
No	0	0	1	20.0
TOTAL	17	100.0	5	100.0

TABLE 57: FREQUENCY OF ATTENDANCE AT FRATERNAL ASSOCIATION MEETINS

	Health Officers		Executive Officers	
Frequency of Attendance (Percentage)	No.	%	No.	%
0 - 25	5	31.3	1	50.0
26 - 50	2	12.5	0	0
51 - 75	3	18.8	0	0
76 - 100	6	37.5	1	50.0
TOTAL	16	100.0	2	100.0

Membership in church related associations was indicated by 23 of the health administrators with Protestant and Catholic Associations accounting for 39% in each category. Jewish Associations accounted for only 4.3% of the total. (Table 58)

TABLE 58: MEMBERSHIP IN CHURCH ASSOCIATION

	Health Officers		Executive Officers	
Church Assn.	No.	%	No.	%
Roman Catholic	7	41.2	2	33.3
Jewish	1	5.9	0	0
Protestant	6	35.3	3	50.0
Other	3	17.6	1	16.7
TOTAL	17	100.0	6	100.0

Reasons for joining church associations were extremely diversified. Joining for the purpose of making personal contacts accounted for only 6% of the toal -- the highest percentage of any specific reason. (Table 59)

TABLE 59: REASONS FOR JOINING CHURCH ASSOCIATION

	Health Officers		Executive Officers	
Reason	No.	%	No.	%
Personal Contact	1	7.7	0	0
Other	12	92.3	4	100.0
TOTAL	13	100.0	4	100.0

Ninety-six per cent are still members of a church related association (Table 60) and 47.4% attend better than 3/4ths of the meetings, although 26.3 attend less than 1/4 of the meetings held. (Table 61)

TABLE 60: CURRENT MEMBER OF CHURCH ASSOCIATION

	Health Officers		Executive Officers	
Current Member	No.	%	No.	%
Yes	16	94.1	6	100.0
No	1	5.9	0	0
TOTAL	17	100.0	6	100.0

TABLE 61: FREQUENCY OF ATTENDANCE AT CHURCH ASSOCIATION MEETINGS

Frequency of Attendance (Percentage)	Health Officers		Executive Officers	
	No.	%	No.	%
0 - 25	3	21.4	2	40.0
26 - 50	2	14.3	0	0
51 - 75	2	14.3	1	20.0
76 - 100	7	50.0	2	40.0
TOTAL	14	100.0	5	100.0

G. Job Satisfaction

A significant part of a person's life involves his particular job. Because of the amount of time one spends in this activity over a lifetime, it is important to consider those aspects of the "job" which are rewarding to the individual as well as those that are frustrating. How satisfied a person is in his particular job role has a number of consequences in terms of career goals and aspirations.

In attempting to gain insights into the extent of job satisfaction which health administrators experience in their job role, as well as the circumstances which bring about dissatisfactions and conflict, a series of questions relative to these issues were raised.

Because the kinds of people with whom we interact during the work day have major bearing on job satisfaction, it was felt important to deal with this first. Essentially, the concern here was to determine the types of people the health administrator is primarily involved with in carrying out his job role, the frequency of these contacts, the purpose of the contact, the legitimate reasons for making the contact, as well as the type(s) of conflict(s) which tend to arise out of the contacts. In addition, other questions were raised concerning the type(s) of problems health administrators experience with their job; some of the activities or tasks which they feel should be added to reinforce their job role, and the reasons for their inclusion; tasks which should be deleted from the job role and the reasons for deletion; and lastly, their relationship with the New Jersey State Department of Health in fulfilling the expectation of their position. The following discussion deals with these areas in order to better understand the forces which come into play in determining the levels of job satisfaction the health administrator has in fulfillings his occupational commitment.

Public Health administrators, like administrators in other occupational and professional settings do not stand as an entity unto themselves. In general, they often rely on the sanction of "significant others" in the many decisions which must be made for successfully fulfilling the functions

of the occupation. Consequently, once an administrator knows his job boundaries and becomes aware of the people who are significant within the particular power structure of the work setting, certain patterns are developed for gaining support on the central issues which are part of his responsibilities.

Among the people most significant in the work life of the health administrator are the President of the Board of Health (as indicated by 24% of the sample), the Mayor (19.7%), township representatives (17%), and representatives from the State Department of Health (16.6%). Not nearly as significant are members of the Health Officer's Association (10%), representatives of the mass media (1%), and representatives from: the educational systems (1.5%), the hospital administration (2.5%), and community service agencies (3.0%). This last response is of interest since responses to a previous question strongly indicated that as a group, health administrators are eager to work with community service agencies. Office staff members in the department account for only 5% of the responses as did the Police and Fire Departments. Interestingly, the local Medical Society representative was reported as significant by only 8% of the sample.

One could anticipate that most contacts are made with (1) the president of the local board of health (especially since he represents the local policy making body), (2) the Mayor (since health is usually a major political concern), and (3) representatives of the State Health Department (since they play a major part in the interpretation of state health policies and laws). What is difficult to explain is the limited contacts made with (1) the Health Officer's Association (their major professional organization) (2) the mass media, (a group that could be quite instrumental in helping the administrator gain public support for activities he is eager to promote), and (3) the educational administration, (particularly since school health is considered a major community concern). Only 0.5% of the respondents indicate that they contact their staff personnel in decision making. Because of the size of most boards of health, most of the staff personnel are not considered "professionals"--and consequently are not looked to for any decision making.

The frequency of contact is of interest in discussing the significant people contacted. Over 1/3 of the contacts are made on a monthly basis. Almost 22% indicate meeting with significant people to discuss

their work at least once a week, while 20% see the key contacts at least several times a week. There is very little differences reported in the responses offered by the Health Officers and the Executive Officers on these matters. (Table 62)

In considering the purpose of the contact, we find that 50% are made over issues concerning "policy and administration", most of these (28%) are directed to the Representative of the State Board of Health, 25% are directed to the President of the Local Board of Health, 14.5% are directed to the Township Representatives, and 12% are directed to the Mayor.

The second major area of concern for contacting key people is in "planning department programs." On this issue both the President of the Local Board and the Mayor are called upon with equal frequency (23%), while State Health Department Representatives and Township Representatives are also called upon for an equal amount (14% each). Aside from the issues of policy, administration and planning department programs, other major reasons offered for contact is merely "to keep key community people informed." In response to this variable, the Presidents are involved 43% of the time, the Mayor 1/3 of the time and the Township Representatives 20% of the time (Table 63).

TABLE 62: MAJOR PEOPLE AND/OR HEALTH ADMINISTRATION AGENCIES CONTACTED

	Health Officers Frequency of Contact							Executive Officers Frequency of Contact						
People or Agency	Daily	Several Times Wk	Once a Wk	Once a Mo	Not Applicable	Other	Total	Daily	Several Times Wk	Once a Wk	Once a Mo	Not Applicable	Other	Total
Pres Bd of Hlth	1	3	10	17	1	1	33	1	2	5	7	0	0	15
Mayor	2	7	5	7	1	6	28	2	1	3	4	0	1	11
Rep State Dept of Health	3	7	4	14	2	3	33	0	0	0	0	0	0	0
Hlth Adminis	0	2	1	1	0	1	5	0	0	0	0	0	0	0
Twnp Repres	2	11	6	4	0	4	27	2	2	0	1	0	2	7
Police & Fire	1	2	2	3	0	1	9	0	1	0	0	0	0	1
Mass Media	0	0	1	1	0	0	2	0	0	0	0	0	0	0
Comm Serv Agcy	1	0	3	0	0	0	4	0	0	0	0	0	2	2
Office Staff	1	0	0	0	0	0	1	0	0	0	0	0	0	0
Hlth Off Assoc	0	1	1	0	0	0	2	0	0	0	0	0	0	0
Med Soc Rep	1	1	1	3	0	9	15	0	0	0	1	0	0	1
Education Adminis	0	1	1	0	0	1	3	0	0	0	0	0	0	0
TOTAL	12	35	35	50	4	26	162	5	6	8	13	0	5	37

TABLE 63: MAJOR PEOPLE AND/OR AGENCIES HEALTH ADMINISTRATORS CONTACT IN DAILY WORK

People or Agency Contacted	Health Officers — Purpose of Contact						Executive Officers — Purpose of Contact					
	Policy & Adminis	Keep Informed	Public Relations	Approval	Other	Total	Policy & Adminis	Keep Informed	Public Relations	Approval	Other	Total
Pres Bd of Hlth	17	10	0	1	2	30	7	7	0	0	1	15
Mayor	9	8	3	1	3	24	3	7	0	0	1	11
Rep State Dept of Health	24	4	0	0	1	29	3	2	0	0	2	7
Hosp Adminis	3	1	0	0	0	4	0	0	0	0	0	0
Twnp Repres	8	5	0	0	8	21	6	4	0	0	1	11
Police & Fire	4	4	0	0	2	10	0	1	0	0	0	1
Mass Media	0	0	1	0	0	1	0	0	0	0	0	0
Comm Serv Agcy	2	0	0	0	3	5	1	0	0	0	1	2
Office Staff	0	1	0	0	0	1	0	0	0	0	0	0
Hlth Off Assoc	2	0	0	0	0	2	0	0	0	0	0	0
Med Soc Rep	4	4	2	0	3	13	0	0	0	0	0	0
Education Adminis	2	1	0	0	0	3	2	0	0	0	0	2
TOTAL	75	38	6	2	22	143	22	21	0	0	6	49

In reviewing reasons why these people are contacted, certain advantages are manifested for the purpose of expediting the job at hand. For example, considering the problem of "abatement", (a major function of administrators), ten of the 23 people (23.4%) giving this as a reason mention Township Representatives, who are essential for the processing of any abatement, in contrast to no responses for the President and only 4.3% for the Mayor on the same issue. Where "exchanging ideas" was noted as the reason, 9 of the 24 (37.4%) responses involved the Mayor, another 4 (16.6%) listed the State Department of Health. When "follow up of health problems" is noted almost 1/3 (24 reporting this reason) contact Township Representative primarily, although 5 of the 23 responses indicated the Medical Society Representative. No mention was made of the Board of Health President or Mayor as a person to contact on this issue, although 4 in each case (State Department of Health and Police and Fire) are usually contacted for "follow-up of health problems". Both the President and Mayor are contacted frequently on matters concerning "approval of policy"-- 14 of the 26 mentioned the President, while 7 of the 26 noted

the Mayor. On this variable, Township Representatives are not contacted.

"Keeping them informed" was one of the major reasons given for why significant people are contacted. Here 19 of the 39 responses noted the President, while 13 mentioned the Mayor (Table 64).

TABLE 64: MAJOR PEOPLE AND/OR AGENCIES HEALTH ADMINISTRATORS CONTACT IN THEIR WORK

People or Agency Contacted	Health Officers — Reasons Why They Are Contacted							Executive Officers — Reasons Why They Are Contacted						
	Keep Them Informed	Approval of Policy	Follow-Up	Not Really Necessary	Exchange Ideas	Expedite Abatement	Total	Keep Them Informed	Approval of Policy	Follow-Up	Not Really Necessary	Exchange Ideas	Expedite Abatement	Total
Pres Bd of Hlth	9	11	0	1	4	0	25	10	3	0	2	1	0	16
Mayor	8	6	0	2	7	1	24	5	1	0	1	2	0	9
Rep State Dept of Health	1	0	4	0	20	2	27	0	0	0	0	7	1	8
Hosp Adminis	1	0	1	0	2	0	4	0	0	0	0	0	0	0
Twnp Repres	1	0	8	1	4	7	21	1	0	0	0	1	3	5
Police & Fire	0	2	3	0	0	4	9	0	0	1	0	0	0	1
Mass Media	1	0	0	0	0	0	1	0	0	0	0	0	0	0
Comm Serv Agcy	0	0	0	0	2	1	3	0	0	0	0	0	0	0
Office Staff	0	0	1	0	1	0	2	0	0	0	0	0	0	0
Hlth Off Assoc	0	1	0	0	2	0	3	0	0	0	0	0	0	0
Med Soc Rep	2	2	5	0	1	3	13	0	0	0	0	0	0	0
Educational Adminis	0	0	0	0	2	1	3	0	0	0	0	0	0	0
TOTAL	23	22	22	4	45	19	135	16	4	1	3	11	4	39

An area of concern in achieving job satisfaction is related to how conflict can be minimized when relating to "significant people". Conflict seems to be of little significance in affecting the job role of the administrator. Eighty-six per cent of those responding to the question "what type of conflict tends to arise" as a result of the contact made with significant people--the overwhelming majority (86%) -- reported that conflict is absent in their contacts. Where conflict is present, it tends to emanate from the various "contacts" reluctance to support the health administrator in his job role (mostly hospital administrators and medical society representatives). Other conflicts arise from political involvement (3.3%)--here the Board President and the Mayor were the only groups cited (Table 65).

It appears that conflict plays a minor role among health administrators in terms of "job satisfaction". A willingness on the part of health administrators to accept the vested interest of contacts in "running the show" might well account for minimizing conflict. Perhaps a better understanding of possible conflict as it affects job satisfaction might be assessed more effectively if one considers a related factor, namely, what does the health administrator see as the peculiar problems of his job.

TABLE 65: MAJOR PEOPLE AND/OR AGENCIES CONTACTED

People or Agency Contacted	Health Officers: Type of Conflict Arising As Result of Contact							Executive Officers: Type of Conflict Arising As Result of Contact						
	None	Narrow View of P.H.	Interference	Difficult to Keep Inf	Politics	Lack of Authority	Total	None	Narrow View of P.H.	Interference	Difficult to Keep Inf	Politics	Lack of Authority	Total
Pres Bd of Hlth	22	1	1	1	2	1	28	14	0	0	0	0	0	14
Mayor	18	0	0	1	3	1	23	7	0	0	0	1	0	8
Rep State Dept of Health	23	1	1	0	0	0	25	7	0	0	0	0	0	7
Hosp Adminis	2	0	0	0	0	2	4	0	0	0	0	0	0	0
Twnp Repres	22	0	0	0	0	4	26	6	0	0	0	0	0	6
Police & Fire	10	0	0	0	0	0	10	1	0	0	0	0	0	1
Mass Media	0	0	0	0	0	1	1	0	0	0	0	0	0	0
Comm Serv Agcy	4	0	0	0	0	0	4	2	0	0	0	0	0	2
Office Staff	1	0	0	0	0	0	1	0	0	0	0	0	0	0
Hlth Off Assoc	2	0	0	0	0	0	2	0	0	0	0	0	0	0
Med Soc Rep	9	2	0	0	0	2	13	0	0	0	0	0	0	0
Educational Adminis	3	0	0	0	0	0	3	1	0	0	0	0	0	1
TOTAL	116	4	2	2	5	11	140	38	0	0	0	1	0	39

Almost 34% of the administrators pose as major the whole area of "administrative problems." Here may exist an underlying conflict situation since most administrators tend to contact and involve the local Board President and the Mayor primarily over problems which are administrative. While almost 16% of the administrators indicate a "lack of public understanding" is a major source of disturbance, there appears to be little effort made toward working closer with representatives of the "mass-media" in gaining support for their programs and health activities. Only 4% indicated political interference as being a problem with their job--none indicated problems with the State Department of Health (Table 66).

TABLE 66: PROBLEMS WITH JOB AS REPORTED BY ADMINISTRATORS

	Health Officers		Executive Officers	
Problems	No.	%	No.	%
Part Time	1	1.7	1	5.6
Lack of Public Understanding	8	13.6	4	22.2
Lack of Enforcement (Codes)	3	5.1	1	5.6
Administration Problems	22	37.3	4	22.2
Program Implementation	4	6.8	1	5.6
Political Interference	3	5.1	0	0
None	4	6.8	4	22.2
Other	14	23.7	3	16.7
TOTAL	59	100.0	18	100.0

As a follow up to this question the administrators were asked "what activities or tasks should be added to the job." Although 35% felt that no activities or tasks should be added, a significant percentage (31%) expressed the desire for "more say so" in the planning of health programs. Still others (11.5%) would like to see more staff added-perhaps to "lighten their own work load". Only 6% expressed a need for the addition of

clinical services (Table 67).

TABLE 67: ACTIVITIES OR TASKS THAT SHOULD BE ADDED AS REPORTED BY HEALTH ADMINISTRATORS

	Health Officers		Executive Officers	
Activity	No.	%	No.	%
Funds	4	9.8	0	0
Legislation	1	2.4	0	0
Enforcement of Ordinances	1	2.4	1	9.1
More Clinics	3	7.3	0	0
More Full Time Staff	5	12.2	1	9.1
Planning Health Programs	14	34.2	2	18.2
Better Facilities	2	4.9	0	0
None	11	26.8	7	63.6
TOTAL	41	100.0	11	100.0

When asked why they felt some of these activities should be added, the most prominent response indicated the "need for improved health services." Others feel a "need for additional personnel" (7.7%); "power" and "progress" accounted for 3.3% each (Table 68).

TABLE 68: REASONS GIVEN FOR ADDING ACTIVITIES

	Health Officers		Executive Officers	
Reason	No.	%	No.	%
Improve Environment	1	5.0	1	16.7
Need Personnel	2	10.0	0	0
More Power	0	0	1	16.7
Curtain Community Health Problems	1	5.0	0	0
Eliminate Politics	1	5.0	0	0
Improve Health Services	10	50.0	1	16.7
Progress	1	5.0	0	0
Other	4	20.0	3	50.0
TOTAL	20	100.0	6	100.0

At the base of this question, the respondents were asked which activities should be deleted. Here an extensive range of activities were suggested, indicating the lack of any real consensus among administrators as to where priorities should be set. It appears that what is peculiarily distasteful to the administrator, rather than a concern for those activities which handicap the occupation as a group from achieving any basic health administrative objectives, fail to draw any degree of

consensus. For example, of the 29 administrators, the area having the highest degree of consensus was concern for "deleting housing responsibilities" from the job (Table 69).

TABLE 69: ACTIVITIES OR TASKS THAT SHOULD BE DELETED

	Health Officer		Executive Officer	
Activity	No.	%	No.	%
Housing	2	8.7	0	0
Emergency Services	1	4.3	0	0
Political Interference	1	4.3	0	0
Weed Control	1	4.3	0	0
Dog Control	1	4.3	0	0
Sewage	0	0	1	16.7
Other	17	73.9	5	83.4
TOTAL	23	100.0	6	100.0

Of the varied and extensive listing of proposed deletions, the predominant reasons given for wishing to have them deleted were (1) public health reasons, (2) avoid duplication on the job, and (3) the need to carry out programs more effictively (12.5% each) (Table 70).

TABLE 70: REASONS GIVEN FOR DELETING ACTIVITIES

	Health Officers		Executive Officers	
Reason	No.	%	No.	%
Public Health Reasons	1	7.7	1	33.3
Eliminate Duplication	1	7.7	1	33.3
Need to Conduct Program	2	15.4	0	0
Related to Building Dept.	1	7.7	0	0
Other	8	61.5	1	33.3
TOTAL	13	100.0	3	100.0

A final question raised regarding job satisfaction of the public health administrator was directed at determining the relationship to the New Jersey State Department of Health. Forty-five per cent of the respondents expressed their belief that the relationship was excellent, while 42% noted that it was good. Although 5.5% stated indifference about this relationship, the ramainder of the respondents (7.5%) noted that their relationship with the State varies--none of the respondents indicated their relationship as bad (Table 71).

TABLE 71: RELATIONSHIP TO NEW JERSEY STATE DEPARTMENT OF HEALTH

	Health Officer		Executive Officer	
Relationship	No.	%	No.	%
Good	16	40.0	7	46.7
Bad	0	0	0	0
Indifferent	2	5.0	1	6.7
Excellent	20	50.0	5	33.3
Varies	2	5.0	2	13.3
TOTAL	40	100.0	15	100.0

H. Career Satisfaction

Closely related to job satisfaction but of greater significance in terms of explaining professional aspirations is career satisfaction. Job satisfaction serves as a yardstick for how well one is integrated into his work role, the daily problems he encounters, the conflicts which create stress in his day-to-day activity, and his daily relationship with others who are significant for him in accomplishing the job at hand. Career satisfaction is a more meaningful index for determining the direction of one's occupational choice during one's life span. It represents the satisfaction gained from the process of moving from a series of

related jobs which have been held in an ordered sequence, and in which each is related to the next. While a job is an isolated interval in the process of earning an income--(the income serving as the main objective for assuming the job), a career reflects "a whole series of future expectations."

The concern here is to determine the public health administrator's satisfactions and/or dissatisfactions, his views and feelings on the direction which public health as an occupation will take in the future, and the effect these changes will have on his occupational choice. Other factors playing a part in career selection and commitment are the occupation of the administrator's father, and the occupation of close friends. Lastly, a person's occupational life objectives and opportunities for advancement in the profession are motivating forces in the selection of a particular occupational career.

A "sense of accomplishment" is a feature which health administrators like best about their career choice (28%), "Public service" is second in importance (19.6%). The opportunity to resolve community problems (18.5%), the challenges which the career offers (12.0%) and the diversification of work assignments (10.9%) rank in that order.

Those areas often associated with occupational careers such as job security (2.2%), prestige (2.2%), and professional recognition (1.1%) were reported accordingly. Of interest is the fact that only 5% of the sample failed to specify a feature which they liked best about their job (Table 72).

TABLE 72: WHAT IS LIKED BEST ABOUT JOB

	Health Officers		Executive Officers	
Reasons	No.	%	No.	%
Variety	7	10.0	3	13.6
Challenge	9	12.9	2	9.1
Accomplishments	20	28.6	6	27.3
Public Service	12	17.1	6	27.3
Security	2	2.9	0	0
Recognition	1	1.4	0	0
Prestige	2	2.9	0	0
Chances to Resolve Problems	12	17.1	5	22.7
None	5	7.1	0	0
TOTAL	70	100.0	22	100.0

The respondents were also asked to state the features they disliked most about their occupational career choice. The foremost response was the "constant

criticism which health administrators receive" (19.6%). Once again, "lack of public awareness" was a major concern (17.9%), while "political involvement in their career" was noted by 16.1%. Public health administrators' responsibility for the "enforcement of health codes" was another form of career disturbance to 14.3%. The management of administrative detail and excessive work demands were other disturbing features, accounting for 10.7% in each instance. "Poor and inadequate salaries" was noted by 5.4%, while "night meetings" accounted for 3.6%. Less than 2% gave field work as one of the features they disliked about their career (Table 73).

TABLE 73: WHAT IS LIKED LEAST ABOUT JOB

	Health Officers		Executive Officers	
Reason	No.	%	No.	%
Lack of Public Awareness	8	17.4	2	20.0
Politics	7	15.2	2	20.0
Criticism	10	21.7	1	10.0
Administration	6	13.0	0	0
Poor Salary	3	6.5	0	0
Excessive Work Demands	4	8.7	2	20.0
Field Work	1	2.2	0	0
Night Meeting	2	4.4	0	0
Enforcement	5	10.9	3	30.0
TOTAL	46	100.0	10	100.0

In response to the changes anticipated in public health, the majority of the respondents (29%) noted greater awareness of public health needs in general, while 19% indicated the trend toward centralized control over public health services. Of interest is the fact that 15% of the respondents believe that an en-evitable major change will be the increasing emphasis on the professionalization of public health workers. Others, (10%) see the inclusion of "preventive medicine" as an important change. "Technical advances in public health" and increasing concern for "environmental health programs" were noted by 9% in each case. Improvement on the "quality of personnel recruited" for public health work accounted for 6% of the sample. Only 1% feels that the "resentment and animosity of physicians" toward non-medical health administrators will become intensified (Table 74).

TABLE 74: WHAT CHANGES WILL OCCUR IN PUBLIC HEALTH

	Health Officers		Executive Officers	
Changes	No.	%	No.	%
Technical Advances	4	7.7	2	11.8
More Awareness	13	25.0	7	41.2
Include Preventive Medicine	7	13.5	0	0
More Central Control	11	21.2	2	11.8
More Federal Involvement	2	3.8	0	0
Professionalization	8	15.4	2	11.8
More Resentment from M.D.'s	1	1.9	0	0
Better Qualified Personnel	4	7.7	0	0
Emphasis on Environmental Health	2	3.8	4	23.5
TOTAL	52	100.0	17	100.0

The administrators were also asked how changes would affect their career. "Increase in public health duties" was cited by 28%. Closely related to this was a feeling that changes in public health will lead to

comprehensive health services (23%). Because of a growing trend toward specialization in public health, 2% felt that "concentration on administrative problems" will free the administrator from other health problems and duties, limiting his overall responsibility. Also related to these responses is their belief that public health personnel will be better trained (17%). Almost 7% of the sample anticipate larger health department budgets. A more desirable image of health departments, an increasing need for team work for accomplishing public health missions, and less challenge in the health administrator's job, were cited by less than 2% of the sample (Table 75).

TABLE 75: HOW WILL CHANGES AFFECT ADMINISTRATOR'S CAREER?

	Health Officers		Executive Officers	
Effect of Changes	No.	%	No.	%
Better Trained Personnel	9	18.7	1	8.3
Increased Duties	13	27.1	4	33.3
Concentrate on Administration	1	2.1	0	0
More Comprehensive Health Service	10	20.8	4	33.3
Less Challenging Job	1	2.1	0	0
Require More Team Work	1	2.1	0	0
Bigger Budgets	4	8.3	0	0
Easier for Health Admin.	8	16.7	3	25.1
Improve Image of Health Dept.	1	2.1	0	0
TOTAL	48	100.0	12	100.0

How we perceive the future is often a major consideration in the choice of a career. If original career goals become unreachable, the choice then is often a career closely related to the original choice.

Only two respondents in each case (4.5%) indicated that their career goal was either to become a Health Officer, or that administration was their career objective. A considerable number, 7 (15.9%) were undecided on a career at the time they became involved in public health, while 7 of the respondents (15.9%) specifically set public health as their career objectives. Five respondents (11.4%) noted a career in public service as their career objective, while medicine, a field close to public health, was a career objective for only one respondent. One respondent indicated engineering, while two noted teaching as a career objective (Table 76).

TABLE 76: WHAT WAS YOUR LIFE OBJECTIVE WHEN CHOOSING A CAREER?

Objective	Health Officer		Executive Officer	
	No.	%	No.	%
Undecided	6	18.8	1	8.3
Engineering	1	3.1	0	0
Administration	1	3.1	1	8.3
Public Service	3	9.4	2	16.7
Medicine	1	3.1	0	0
Teaching	2	6.3	0	0
Health Officer	2	6.3	0	0
Public Health Work	6	18.8	1	8.3
Other	10	31.3	7	58.3
TOTAL	32	100.0	12	100.0

In response to the question, "What are the opportunities for advancement in the profession", the majority (26.2%) indicate that the opportunities are "good", while 19% indicate that they are "limited". However, (32.3%) of the respondents indicate that the opportunities appear to be either limited, or non-existent. Motivation in seeking advancement in the profession accounted for 7.1% of the sample (Table 77).

TABLE 77: WHAT ARE THE OPPORTUNITIES FOR ADVANCEMENT IN THIS PROFESSION?

	Health Officers		Executive Officers	
Opportunities	No.	%	No.	%
Good	18	58.1	6	54.5
Not Good	13	41.9	5	45.5
Total	31	100.0	11	100.0

P (X^2 = 0.02)

Regarding the type of occupation held by the respondent's father, most (40%) were in the skilled trades. Of the total, 13% of their fathers held white collar positions. Merchants and laborers accounted for 11% respectively, while 9% were members of a profession other than medicine. Ironically, Health Officers, along with farmers, medical and dental professionals account for 4% of the sample respectively. The para-medical

occupations were reported with least frequency (2.2%) as their father's occupation (Table 78).

TABLE 78: FATHER'S OCCUPATION

	Health Officers		Executive Officers	
Occupation	No.	%	No.	%
Farmer	1	3.0	1	8.3
Merchant	4	12.1	1	8.3
Skilled Trades	12	36.4	6	50.0
Para-Medical	1	3.0	0	0
Health Officer	2	6.1	0	0
Laborer	2	6.1	3	25.0
White Collar	5	15.2	1	8.3
Medical and Dental	2	6.1	0	0
Professions other than Medical	4	12.1	0	0
Total	33	100.0	12	100.0

In determining the occupations of the people public health administrators tend to associate with most, the administrators were asked to indicate the occupation of their three closest friends. Seventeen of the 47 (36%) respondents indicated that their closest friend was in a profession other than medical. Among the second closest friend, the response was 18 out of 47

(31%) while the response for the third friend was 10 out of 46 (22%) indicating a profession other than medical. The occupation reported second in frequency for close friends was that of white collar worker with the distribution being 7 out of 47 (15%) responses for the first friend, 10 out of 47 (21%) for the second friend, and 16 out of 46 (35%) for the third friend. Third in popularity as the occupation of the three closest friends was the skilled trades (7 out of 47, (15%) 5 out of 47 (10%), and 6 out of 47 (13%) respectively). The para-medical field ranked fourth with a cumulative total for all three friends of 13. The cumulative total for friends who are members of the medical and dental profession accounted for 12, while a total of nine Health Officers were listed as friends. Farmers or laborers accounted for a total of three in each category, while merchants accounted for a total of four (Table 79).

TABLE 79: OCCUPATION OF THREE CLOSEST FRIENDS REPORTED BY HEALTH ADMINISTRATORS

	Health Officers Friends						Executive Officers Friends					
	#1		#2		#3		#1		#2		#3	
Occupation	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Farmer	1	3.1	0	0.	1	3.1	0	0	1	6.7	0	0
Merchant	1	3.1	1	3.1	2	6.3	0	0	0	0	0	0
Skilled Trade	3	9.4	1	3.1	4	12.5	4	26.7	4	26.6	2	14.3
Para-Medical	2	6.3	5	15.6	3	9.4	2	13.3	0	0	1	7.1
Health Officer	6	18.8	1	3.1	1	3.1	0	0	0	0	1	7.1
Laborer	0	0	1	3.1	0	0	0	0	1	6.7	1	7.1
White Collar	5	15.6	8	25.0	11	34.3	2	13.3	2	13.3	5	35.7
Medical &/or Dental	3	9.4	3	9.4	3	9.4	1	6.7	1	6.7	1	7.1
Profession Other Than Medical	11	34.4	12	37.5	7	21.9	6	40.0	6	40.0	3	21.4
Total	32	100.0	32	100.0	32	100.0	15	100.0	15	100.0	14	100.0

The above offers a general and descriptive profile of the health administrator typically found directing the health affairs of many New Jersey communities.

CHAPTER VI

CONCLUSIONS

This exploratory study has attempted to focus on the occupational role of public health administrators in New Jersey. In doing so, we have considered theoretical formulations and concepts which have important significance for understanding the health administrator as an occupational group striving toward professional recognition.

It is hoped that this study will suggest other studies in the combined fields of occupational sociology and medical sociology. The hypotheses noted at the outset should suggest further exploration toward better understanding of how emerging occupational groups function in health and/or medical settings -- the roles they play -- the conflicts they face -- the stresses they undergo -- the image they create. Further, some of the conceptualizations in the "world of work" should suggest other undertakings, using as major parameters the concept of professions, marginal professions, "ideal types" and bureaucracy.

Central to this study has been an attempt to determine the occupational situs of the health administrator. It has been clearly shown that the occupational situs of licensed Health Officers is considerably more

complex than that of their counterparts, Executive Officers. As noted, Health Officers play a more active part with professional associations, are more involved with official agency programs (the State Department of Health in particular), serve on the boards of Voluntary Health Agencies, and are in general active participants with community service agencies. It is apparent that the Health Officers' occupational situs is enabling him to move closer to the realization of full professional recognition.

As part of the concluding remarks, the hypotheses presented earlier are discussed here in light of the data collected. This approach has made it possible to elicit and to better understand the occupational role of health administrators. These clues also make possible projections about the health administrators' occupational place in the world of work, particularly toward qualifying as professionals. The hypotheses and comments follow:

1. COMMUNITY GROUPS AND PROFESSIONS SIGNIFICANT TO THE HEALTH ADMINISTRATOR TEND NOT TO PERCEIVE HEALTH ADMINISTRATORS AS FUNCTIONING IN A PROFESSIONAL ROLE. THEREFORE MOST DECISIONS ON COMMUNITY HEALTH MATTERS ARE

OFTEN SUBJECT TO SCRUTINY AND APPROVAL BY THESE GROUPS AND PROFESSIONS.

Where administrators are licensed Health Officers there is a tendency for their participation and membership to be welcomed by the various community associations and agencies. This is clearly evidenced by the greater participation in all types of community associations and agencies by Health Officers in comparison to Executive Officers, (see tables 50-61).

While Executive Officers tend to avoid involvement with these groups, because of this exposure, Health Officers believe they are beginning to be viewed in a new light by community groups. They are being given recognition and are looked to for advice and counsel regarding many health, welfare and other community matters. As the number of Health Officers increase -- and with the decline of Executive Officers and part-time administrators serving as the "chief administrator", -- the occupation is becoming more firmly established. The licensed Officer is playing an increasing role in community activities as an active member and participant of local community agencies and associations.

Yet as a collective whole the health administrator shows increasing involvement with professional and community

agencies. Evidence of this is seen in the fact that while over 50% are actively involved with the more significant professional associations (American Public Health Association and New Jersey Public Health Association), almost one half of those involved with civic organizations do so with voluntary community and welfare agencies,(see table 46).

Undoubtedly the occupation's members' growing involvement in the community at large, as one possessing a particular expertise in a special field of training is seen by the administrator as a sign of greater respect for the profession.

Where administrators are called upon with greater frequency by community associations, there has developed a subtle advantage for the administrators in that it has provided them with opportunities to "vent" their problems and needs with these groups -- in effect using them as sounding boards about health problems and programs, as well as gaining their support.

2. AN IMPORTANT FUNCTION OF HEALTH ADMINISTRATORS LIES IN THEIR ABILITY TO RESOLVE CONFLICTS ARISING OVER HEALTH POLICIES AND ISSUES CONCERNING TWO OR MORE HEALTH BUREAUCRACIES WITH WHOM THE HEALTH ADMINISTRATOR MUST MAINTAIN A CONGENIAL

RELATIONSHIP AS PART OF HIS "WORK ROLE".

Conflict seems to play a minor role among administrators in their work relationships. This may be explained in terms of informal but clearly defined relationship roles which are an inherent part of the administrator's occupational role. In order to secure his job status, it becomes advisable for the administrator to go through the appropriate channels and in a sense not "rock the boat". But as the expert in those areas, the administrator is the one most likely sought to serve as mediator and to come up with solutions acceptable to all.

The fact that health administrators indicate that conflicts are at a minimum does not necessarily mean that there is an absence of conflicting situations. What does seem to be happening is that with increasing training and experience health administrators, and Health Officers in particular, have in many cases, anticipated conflict areas and have managed to avoid the emergence of conflict by carefully redefining their role, interpreting the potential problem areas and offering alternative solutions to those concerned.

Also, because health administrators (Health Officers in particular) often see their dominant role as that of mediator between the local board president and the State Department of Health representative, they tend to be in contact with them more frequently in order to more effectively anticipate emerging problems. Thus potential conflicts may be resolved early, and to mutual satisfaction.

For example, contacts by Health Officers with Local Board of Health representatives account for two fifths of all their contacts (20% with each). Forty per cent of all Executive Officer contacts are with Board of Health representatives and almost 25% with State Department of Health Representatives, (see Table 71).

As long as health administrators (Health Officers in particular) maintain a congenial relationship between the two existing bureaucracies - Local Board of Health and State Department of Health, their own image as professionals will be enhanced and they will be in a better position to gain support from both.

As the number of full-time Health Officers increases, the occupation should gain a degree of solidarity. From this feeling of occupational solidarity, Health Officers will be in a better position to bargain

collectively and effectively with the State Department of Health in establishing programs and priorities that in their "professional opinion" will be saleable to the local board of health as well as of help in reinforcing their own professional role.

3. PUBLIC HEALTH ADMINISTRATORS WHO EXPRESS A HIGH DEGREE OF JOB AND CAREER SATISFACTION ARE MORE LIKELY TO SEE THEMSELVES AS "PROFESSIONALS"; CONVERSELY, THOSE WITH A LOW DEGREE OF JOB AND CAREER SATISFACTION ARE LESS LIKELY TO SEE THEMSELVES IN A PROFESSIONAL ROLE.

While health administrators as a group tend not to display much job and career satisfaction, there are marked differences when the two groups of administrators are separated. Health Officers in general express a higher degree of job and career satisfaction and tend to be considerably more professionally oriented. Many tend to indicate that appointments for advancement are good. In fact when asked what they felt were the opportunities for advancement in this profession, over 57% of all administrators indicated that opportunities were good,(see table 77). Executive Officers do not actually express job or career disatisfaction, but are

less likely to see themselves as professionals. As a matter of fact, Executive Officers show very little aspiration toward becoming licensed as Health Officers or of ever achieving Health Officer status. This is clearly evidenced by the fact that only 21.4% of Executive Officers surveyed indicated any aspiration toward becoming a Health Officer, (see table 41). Their lack of aspiration however, may be due to the fact that they recognize that they cannot meet the minimum requirements for a variety of reasons. Collectively Executive Officers see themselves as the "mechanics of the trade" and view Health Officers (and Health Officers concur with this) as the "engineers".

Unlike Health Officers, Executive Officers are much more reluctant to accept new responsibilities in their job role. Accordingly they feel a degree of job saturation. Further responsibilities would tend to spread them thinner in their job role which already includes a wide range of activities. Also, since many Executive Officers serve in a part-time capacity, (73.3% as compared to 10.5% for Health Officers, see table 16), it is probably difficult for them to think in terms of a career pattern. When one is employed

in a variety of jobs -- none of which is full-time-- it becomes difficult to view any of them in terms of a career. Because most Health Officers are full-time and are more likely to think along the lines of a single occupational career, it consequently becomes easier to aspire to full professional recognition.

4. IDEAL BEHAVIOR PATTERNS OF HEALTH ADMINISTRATORS INCORPORATE MANY CHARACTERISTICS USUALLY ASSOCIATED WITH ESTABLISHED PROFESSIONS. HOWEVER WHEN PLAYING OUT DAILY JOB ROLES, HEALTH ADMINISTRATORS FAIL TO REFLECT THIS IMAGE.

While the cultural norms of the occupation of public health administration has established requirements and regulations characteristic of many professions, i.e., licensing, educational requirements, examinations, etc., many health administrators do in fact fail to reflect the "professional image". Although "professional requirements" do exist (see appendix VII), the public at large is not aware of them. However this is rapidly changing since the more professionally minded Health Officers recognize that their acceptance in the community as a professional hinges heavily on their

involvement in matters of community concern. They will recognize the need to continually expose themselves by offering their services to the community and by becoming actively involved in the more significant community agencies, addressing community groups on their health problems and programs, and in general by extending their occupational "situs" to include activities that will clearly remove them from a marginal professional status to one of full professional recognition.

Much of this is evidenced when one examines select characteristics usually associated with established professions. In this respect, the acquisition of professional licenses is far greater for Health Officers (a total of 85 as compared to 23 for Executive Officers), (see table 9). This however, is somewhat skewed by the fact that of the total of 85 licenses held by Health Officers, 42 (almost 50%) were Health Officer licenses. Also, Health Officers outnumber Executive Officers by a ratio of almost 3 to 1.

In regard to educational achievement, almost 90% of the Health Officers have attended college as compared to 27.3% of the Executive Officers, (see table 10). In the area of specialty training, Health Officers were involved in a total of 74 training programs as compared to 26 programs for Executive Officers, a ratio of almost 3 to 1, (see table 11).

Academic rank at an institution of higher learning shows that only six administrators held the rank of instructor, all Health Officers, (see table 21).

Professional papers read and/or published usually had been considered an important index in determining professionalism. In this respect Health Officers read and/or published 23 papers as compared to 9 for Executive Officers, (see table 24). Membership in professional associations, also an important index, substantially favors the Health Officers with memberships in a total of 82 professional organizations as compared to only 12 for Executive Officers, (see table 46).

Increasingly, licensed Health Officers show every indication of striving to achieve the ideal behavior patterns of the occupation. For them public health tends to be a "full time" activity with 89.5% serving full-time compared to 26.7% of Executive Officers serving full time, (see table 16). Their role is more clearly becoming that of a health administrator in accordance with the norms incorporated in the formal structure. Executive Officers, however, because they view themselves as "jacks of all trades" within the occupational structure, fail to reflect ideal behavior

patterns of the occupation to the same degree, and, as a consequence, do not reflect a professional image. Despite the existing regulations, many administrators (primarily Executive Officers) are filling jobs at a level below these requirements. Also, many of the tasks fulfilled by administrators rightly fall under the category of Sanitary Inspector.

5. OCCUPATIONAL SUCCESS IS PRIMARILY DEFINED BY PUBLIC HEALTH ADMINISTRATORS IN TERMS OF FINANCIAL ACHIEVEMENT RATHER THAN ON THE BASIS OF JOB AND CAREER SATISFACTION.

Financial achievement does not appear to be a significant variable in the determination of occupational success for health administrators. On the contrary, very few indicate that financial remuneration or achievement is an important factor either in their present job or in terms of their career projection. This is somewhat surprising since two-thirds of the Executive Officers sampled reported an income of less than $10,000 per annum, (see table 8). It is interesting to note that 12% of the Health Officers gave salary as their primary reason in becoming a health administrator, while none of the Executive Officers surveyed indicated salary as the primary reason. Over 8% of the Health Officers and 10% of

Executive Officers gave salary as a secondary reason, (see table 30). As a matter of fact, only six Health Officers and one Executive Officer indicated that low salaries represents an obstacle which may lead to failure as a Health Administrator, (table 39). Further, when asked what they liked least about their job, only three Health Officers and none of the Executive Officers indicated poor salary as a factor, (table 73). However, as the qualifications for public health administration positions are upgraded, it is likely that their income level will improve. As Health Officers continue to demonstrate their professional worth, they will then be able to expect commensurate compensation.

By and large occupational success is expressed in terms of job and career satisfaction. Interest in the medical and related fields, family involvement in health administrative matters, as well as dedication to the health field are major variables in determining their occupational success. Another variable of occupational success is the degree to which they are involved with significant others (president, local board of health, and representatives of State Department of Health and township representatives), (see table 71). Extensive involvement with those significant to their occupation provides the administrator

with a feeling of prestige, in that those significant to the health administrator are often people who are significant in other areas of community life, such as mayors. Consequently being in the company of the significant leaders tends to improve his own professional image.

6. EXECUTIVE OFFICERS TEND TO HOLD LITTLE ASPIRATION FOR BECOMING LICENSED AS HEALTH OFFICERS; THEY HOLD LITTLE ASPIRATION FOR ACHIEVING "HEALTH OFFICER" STATUS.

As mentioned earlier Executive Officers in general hold little or no aspiration for becoming licensed as Health Officers, only three indicated any aspiration in this direction, (see table 41). Most feel that the present requirements are too high. As a group, Executive Officers fail to see themselves as professionals and think of themselves as "skilled workers" in the community. While they do not manifest animosity toward the Health Officer, there is an underlying resentment toward the growing recognition which licensed Health Officers are receiving both by the State Department of Health and the community at large. In essence they tend to resent the emerging role of the

licensed Health Officer, and the fact that Executive Officers are increasingly playing a secondary role in community health affairs.

What is also disturbing to Executive Officers is the fact that the "new breed" of Health Officer has less interest in field work and more concern for paper work. Many Executive Officers are beginning to question the Health Officer's ability to function effectively in administering the health matters of the community if he fails to become involved in field work.

As members of an occupational group, Executive Officers fail to express aspiration toward upward mobility. They seem to lack the interest of creating a professional image which can be used as an incentive for recruiting other members into the occupation. The mere fact that Executive Officers themselves fail to aspire toward Health Officer status can hardly be an inspiration to those in search of an occupation in public health through which they might fulfill their "professional" aspirations.

In Chapter III, "The Sociology of Work", an attempt was made to discuss the concept of work in light of its various implications for the health administrator. For the purposes of this discussion one

professional model has been selected, that of A.R. Carr-Saunders. There are several important reasons for selecting this "professional model". In the first place Carr-Saunders was one of the first scholars to carefully investigate the concept of the "professions" and to offer a number of meaningful criteria for their analysis. Secondly, his model has survived the test of time. And thirdly, other models concerning the professions are in part modified versions of Carr-Saunders' model.

Included in Carr-Saunders' criteria for professionalization are the following:

1) Specialized skill and training.

2) Minimum fee or salary.

3) Formation of professional associations.

4) Codes of ethics governing professional practice.

5) Degree to which associations seek to establish minimum qualifications for entrance into professional practice.

6) Enforcement of appropriate rules and norms of conduct among members of the group.

7) Ability to raise the status of the professional group in the larger society.

To what extent are these criteria applicable to the public health administrator? A discussion to this point follows.

1) Specialized Skill and Training

Because of the increasing complexity and demands which are being made of the health administrator in his occupational role, there is an intensification and broadening of specialized skills and knowledge required. This need for greater knowledge of the field in order to function more effectively has formed the basis for health administrators' demand for higher wages for the work they perform, commensurate to other professional bodies. Recognizing that specialized skill and training are vital to their own professional growth, health administrators are banding together for the purpose of establishing and participating in professional associations working (Health Officer's Section, American Public Health Association, and New Jersey Health Officers Association) toward this goal, (see table 46).

2) Minimum Fee or Salary

By and large health administrators receive their financial remuneration on a salary basis. This is particularly true in cases where the administrator

is licensed, is employed full-time at one job, and works on an annual salary contract basis. Where administrators serve more than one community, a fee arrangement is often worked out based on the services provided. However, the trend is swiftly moving toward full-time administrators compensated on a yearly salary with 89.5% of Health Officers currently employed on a full-time basis, (see table 16). Health administrators are increasingly accepting the notion that as "professionals" they must accept the fact that theirs is not a 9-5 job, and that, irrespective of their salary, they must be prepared to work on the basis of the particular demand of the job regardless of hours.

3) Formation of Professional Associations

Some reference has already been made concerning this point (see (a) above). Nonetheless an additional comment is in order. The increasing participation of health administrators (particularly Health Officers) with professional associations as noted in table 46 seems to testify to the fact that administrators are actively participating in associations which offer avenues for professional progress and recognition in the health/medical community and among the citizens they serve. Increasingly there is an

awareness that here may well lie their hopes for the future as a "professional" body.

4) Codes of Ethics Governing Professional Practice

As an outgrowth of professional associations and minimum entrance requirements for admission to the occupations, a code of ethics ("Minimum Standards of Performance") has evolved for health administrators. Adherence to this code by this occupational group will play a major part in moving them toward professional status.

5) Degree to Which Associations Seek to Establish Minimum Qualifications for Entrance into Professional Practice

A major function of professional associations is that of consistently applying pressure as interest groups in the establishment of minimum entrance (examining) requirements, (see Appendix VII). In this respect they are receiving full support from the New Jersey State Department of Health.

6) Enforcement of Appropriate Rules and Norms of Conduct Among Members of the Group

The State Sanitary Code and other documents noted earlier tend to regulate and enforce the rules and norms of conduct of this group. Increasingly, the

licensed Health Officer is demanding, through his professional affiliations, that the State Department of Health enforce all aspects of the Sanitary Code. It is through this instrument that considerable regulation and standardization of job roles are accomplished within the occupation.

7) Ability to Raise the Status of the Professional Group in the Larger Society

As health administrators continue to acquire specialized skills and training, demand a responsible salary for the work they perform, form effective professional associations, establish, refine and redefine a meaningful code of ethics for the purpose of governing their professional practice, continue to establish minimum qualifications for entrance into their occupational group, enforce norms and rules of conduct appropriate for their membership, they will undoubtedly effectively raise the status of their group in the larger community. Perhaps the next decade will be a crucial period for this occupational group to move more forcefully as full fledged members of the professional arena - or remain marginal as professionals.

As health administrators continue to move into a professional role they will have to face and solve many problems, remove many obstacles, and obtain

support and sanction from many groups and individuals which are significant to them in their occupational career. Undoubtedly a considerable amount of social stress and strain will occur as administrators attempt to carve a new career perspective for themselves. Their efforts will require greater support from medical groups and health and medical personnel working in allied and para-medical occupations. Above all they will have to gain the respect, support, and recognition of community leaders so that they may be able to accomplish the goals of the local board of health and the goals of the occupation.

The health administrator's "occupational situs" will out of necessity require that he reach out and become increasingly involved with groups that will enhance his position as an administrator and as a professional. Certainly, the major bureaucratic structure to which he must respond will in all probability continue to support the occupation by establishing norms that will require those factors which are characteristic of professional groups.

The non-medical Health Officer, like the non-medical hospital administrator has shown that he is capable of administering the health affairs of

municipalities in New Jersey. Where they have been trained as public health administrators, they have indicated their ability to manage the community's health needs more effectively than physicians for a variety of reasons.

First of all, physicians serving in the capacity of local Health Officers are in the main part-time employees. Health administration is usually a secondary concern to them. It is difficult to consider a part-time position as an important part of anyone's occupational life -- except for the financial remuneration which one might receive for these part-time services. If one is to be effective in a job role -- and think in terms of a career pattern -- that occupational role should require one's work energies almost exclusively. Where physicians or sanitarians are serving a community on a part-time basis, the services rendered must be limited, and the community cannot rationally view the position as a significant one in the community. As a consequence the community suffers from limited services and does not get the expert direction that would be available from a full-time and properly trained administrator.

Likewise the occupation suffers since it can hardly aspire toward professional recognition when its members are part-time and basically trained in areas other than public health administration.

Secondly, physicians while trained in the art of medicine, are usually not trained in administration, public health, or environmental sciences. Lack of proper training in these areas results in judgments and decisions often made on the basis of hunches rather than on actual knowledge. In matters which affect the total community's well-being, a major risk is taken when judgments are made on limited knowledge.

Thirdly, physicians traditionally are trained to relate on a one-to-one basis, rather than within a system of relationships. Recognizing that an important part of public health administration involves many phases of public relations, unless one is involved in a full network of relationships, health goals and objectives may be difficult to implement effectively. The whole idea of simultaneous interrelationships at many levels is an important aspect of public health administration. Unless these relationships are developed and maintained, the full

effect of public health programs can be seriously curtailed.

The trained non-medical licensed Health Officer who is employed in the occupation full-time, who has been trained and understands administrative procedures and public health concepts, who is community oriented and is accustomed to working in a system involving many relationships, should certainly be a significant candidate for helping communities meet their health needs. Perhaps the example and experiences of New Jersey in introducing a non-medical licensed public Health Officer as its Chief Administrator should be considered by other states faced with the difficulty of adequately paying and/or recruiting physicians to serve in these important positions.

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APPENDICES

N.J. HEALTH OFFICERS ASSON. PROTECTION AVOIDS CURE.

New Jersey Health Officers Association 179

ORGANIZED 1911 INCORPORATED 1962

PRESIDENT
LOUIS C. TAUSCHER
IRVINGTON, N. J.

PRESIDENT-ELECT
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201 - 743-4400

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I. Letter of endorsement:
Health Officers Association

December 11, 1968

Mr. Mark A. Quinones, Director
TB/Respiratory Disease Assoc. Inc.
Route 15 South, R.D. #1
Lake Hopatcong, New Jersey 07849

Dear Mr. Quinones,

This is to inform you that the Executive Committee of the New Jersey Health Officers Association has endorsed your Sociological study of the occupational role of the health officer in New Jersey.

This Association will offer every cooperative effort, within its ability, to aid you in your study.

Please call upon me at any time, for my projected trip to California has been cancelled.

Sincerely yours,

Kenneth M. Jones
Secretary-Treasurer

KMJ:jd

II. Letter of endorsement
New Jersey State
Department of Health

State of New Jersey

DEPARTMENT OF HEALTH

NORTHERN STATE HEALTH DISTRICT

61 SUNSET STRIP, SUCCASUNNA, 07876

Area Code 201 • 584-8121

August 8, 1968

Mark A. Quinones, Director
TB/RD Association
Route 15, South, R.D. 1
Lake Hoptacong, New Jersey 07849

Dear Mr. Quinones:

I have discussed your study "The Health Officer in New Jersey" with Dr. Dougherty, pointing out to him your objectives and your proposed interview procedures. Dr. Dougherty is in agreement that such a study will be of benefit not only to the State Department of Health, but also to the New Jersey Health Officers Association and, of course, its members.

It pleases me, therefore, to forward to you this endorsement of the State Department of Health for your future activities in behalf of your study. I feel certain that once the objectives of your study is explained to the several health officers chosen for personal interviews, they will be more than willing to assist you.

Dr. Dougherty and I, as well as Dr. Kandle, will be interested in seeing your complete report when it is finished.

Sincerely,

Donald S. Myers

Donald S. Myers, M. D.
District State Health Officer

DSM/dvs

III. Covering Letter for Questionnaire

NEW JERSEY COLLEGE OF
MEDICINE AND DENTISTRY

24 BALDWIN AVENUE
JERSEY CITY, N.J. 07304

W. S. Applegate, H.O.
P.O.Box 98
Neptune City, Boro, N.J. 07753

Dear Mr. Applegate:

As part of the requirements for a Ph.D. degree in medical sociology, I am undertaking an intensive study of the occupational role of local health officials in New Jersey. As you can see from the attached, the study has received the joint endorsement of the New Jersey Health Officers Association and the New Jersey State Department of Health.

In order for the study to be a success, it will be necessary for health officials currently in charge of the administrative affairs of local health jurisdictions in the state to complete the enclosed questionnaire. As a local health administrator, I would appreciate it if you would complete this questionnaire and return it at your very earliest convenience, in the enclosed self-addressed envelope. The questionnaire should not take more than one hour to complete, since the questions are solely concerned with activities related to your occupational role as a health official.

Thanking you in advance for your cooperation in this matter, I remain,

Sincerely yours,

Mark A. Quinones

MAQ/j

OCCUPATIONAL STUDY OF THE HEALTH OFFICER

NOTE: The information obtained through this questionnaire will be used for statistical purposes only and no reference will be made to any individual. In answering questions, please write legibly and be as brief and candid as possible.

I. IDENTIFYING CHARACTERISTICS? (complete the following)

1. Official Title: Health Officer_____ Executive Officer_____
2. Area Serviced: _____
3. Do you live in the area you service: yes_____ no _____
4. Are your headquarters located in your home ____, office____.
5. Age: _____
6. Sex: Male_____ Female _____
7. Marital Status: Single___; Married___; Widowed:___
   Divorced: ___
8. Residence: a) Rent____; b) own ____; c) other _____.
9. Income Group: a) under $7,000 ____; b) 7-10,000 ____;
   c) 10-13,000 ____; d) 13-16,000 ____; e) 16-19,000 ____;
   f) 19-22,000 ____; g) 22-25,000 ____; h) 25,000 & over ____.
10. Professional Licences held:

License	State	Year Issued

11. Education:

a. College training by degrees earned and major area of emphasis:

	Degree	Major
Bachelor:		
Master:		
Doctorate:		
Other:		
None:		

b. Specialized Training:

Type of Training	Institution	Dates Attended	Certificate or Diploma

II. WORK EXPERIENCE

1. How many years have you been employed in public health work? _____

2. How many years have you been employed in your present position? _____

3. What other public health positions have you held:

Position(s)	Tenure

II (continued)

5. Is your present position full-time? yes_____ no _____.

6. Do you hold other positions and if so, how much of your work week do you devote to them?

Position(s)	Time

7a. Which of the above positions is most important to you?

_____

b. In what ways? Why?

_____

_____

_____

_____

_____

_____

8. Do you hold any position or have any relationship with a teaching institution? yes _____ no _____

What is your title _____

What is the institution? _____

What are your duties? _____

_____

_____

III. RECRUITMENT

1. How did you become interested in public health work as an occupation?

2. What made you decide to be a health administrator?

3. Were there other factors? Please list.

4.a. Was any training required for this position?_____

b. If so, what was it and for how long were you trained?

Training	Where	By Whom	Length of Training

5. Do you feel that you have received adequate training for your present position? yes _____ no _____

6. How do you feel a health administrator <u>should</u> be recruited?

7. How do you define a successful health administrator?

III (continued)

8. Since becoming a health administrator, have you received any formal (college credit, workshops, seminars, etc.) public health training? yes _____ no _____

9. What are the obstacles (cliches) which lead to failure for a health administrator? (please list)

_____

_____

_____

_____

_____

_____

10. If you are presently an Executive Officer, do you aspire to become a Health Officer? yes _____ no _____
Please explain:

_____

_____

_____

_____

_____

_____

IV. COMMUNITY SETTING

1. Do you believe that a health administrator should live in the community in which he works? yes _____ no _____
Please explain;

_____

_____

_____

_____

_____

_____

IV. (continued)

2. a) Has the health officer's place within the total community changed much during the past five years? yes ____ no____

   b) If yes, changed in what respect? _____

   c) If no, why hasn't it? _____

3. Do you anticipate changes in the future? yes _____ no _____
   If so, what? _____

V. MEMBERSHIP AND PARTICIPATION IN COMMUNITY ORGANIZATIONS

1.

Name of Organization	Reason for Joining	Still Member?	Attendance: Percent 0-25	25-50	50-75	75-100	Position or Office Held Present	Past	Dates
Professional									
Civic									
Fraternal									
Church									
Other									

V. (continued)

2. List professional papers which you have read and/or published:

Papers (Titles)	Read	Published	When	Where	Group Composition

VI. JOB SATISFACTION

1. What are the problems with your job? _____

2. a. What activities or tasks would you like to see added?

   b. Why? _____

3.a. Which would you like to see deleted? _____

VI. (continued)
3.b. Why? _____

_____

_____

_____

_____

_____

4. Describe your relationship with the New Jersey State Department of Health:

Good ____ Bad _____ Indifferent _____ Excellent _____

5. Indicate major people and/or agencies whom you contact in your work. Do not include people whose work you supervise, i.e., staff personnel.

Major people and/or agencies contacted in your work.	(Please check) Frequency of Contacts: At least daily	Several times a week	At least once a week	At least once a month	What do you contact them about?	Why is it necessary for you to contact them?	What conflict does their involvement pose?
President-Board of Health							
Mayor							
President-Medical Society							
Representative District Health Department (Title)							

5. (continued)

Others (list titles)	At least daily	Several times a week	At least once a week	At least once a week	What do you contact them about?	Why is it necessary for you to contact them?	What conflict does their involvement pose?
Title							
Title							
Title							
Title							
Title							
Title							
Title							

VII. CAREER SATISFACTION

7.a) What do you like best about your career in public health?

b) What do you like least?

2. a. What changes do you see in the field of public health?

b. How will they affect the health official's job?

VII (continued)

3. What is (or was) your father's occupation? _____

_____

4. What are the occupations of your three closest friends?

1. _____

2. _____

3. _____

5. What was your life objective when you decided to make public health a career? _____

_____

_____

_____

_____

6. What are the opportunities for advancement in this profession?

_____

_____

_____

_____

_____

NEW JERSEY COLLEGE OF
MEDICINE AND DENTISTRY

24 BALDWIN AVENUE
JERSEY CITY, N.J. 07304

V. 1st Follow-up Letter

Sometime ago you received a questionnaire relative to a study being conducted on the occupational role of the health administrator in New Jersey. As you will recall, the study has received the full endorsement of the New Jersey Health Officers Association and the New Jersey State Department of Health. Upon completion, it will be submitted as part of the requirements for a Ph. D. degree.

If you have already answered and returned the questionnaire, please accept my sincere thanks for your promptness and cooperation. If not, won't you kindly return the completed questionnaire today, since the validity of the study depends on the number of responses obtained from the health administrators throughout the State. Remember, your responses will be kept confidential and will be used for statistical purposes only. When completed, the findings will be extremely helpful in the future selection and training of health administrators for the State.

Please help make this study a success by completing the questionnaire and returning it today! Your cooperation will be greatly appreciated.

Sincerely,

Mark A. Quinones

MAQ:lb

NEW JERSEY COLLEGE OF
MEDICINE AND DENTISTRY

24 BALDWIN AVENUE
JERSEY CITY, N.J. 07304

VI. 2nd Follow-up Letter

Public health can make significant strides in New Jersey, if an effective recruitment and training program for health administrators were established. This, however, requires a careful analysis of the role which the present health administrators play in the health activities in the State. For this reason, an attempt to undertake a comprehensive study of the health administrator is being made with the full cooperation of the New Jersey Health Officers Association and the New Jersey State Department of Health.

You will recall having received a questionnaire sometime ago requesting basic data for the study. Since we did not receive completed questionnaires from all the health administrators, we are again writing to you.

The success and validity of this study depends on the number of health administrators which complete and return the questionnaire. Remember, your response will be used for statistical purposes only, and no reference will be made to any individual. Therefore, if you have not already done so, we would appreciate your completing and returning the questionnaire now, so we may proceed with the analysis, and be ready to give a progress report in the Fall.

Your cooperation will be greatly appreciated and will result in a significant contribution to administrative health planning for New Jersey.

Sincerely,

Mark A. Quinones

MAQ:lb

VII: Qualification for Admission to Licensing Examination for Health Officer and Sanitary Inspector as Effective July 1, 1967

Qualifications for the Health Officer's license are the following:

(1) Diplomate of the American Board of Preventive Medicine

(2) Degree of Master of Public Health from a school of public health accredited by the American Public Health Association.

AND

Satisfactory completion of two years full time working experience in a position requiring administrative responsibility for public health programs of a scope and nature acceptable to the State Department of Health for such experience.

OR

Satisfactory completion of one year full time planned working experience with the State Department of Health.

(3) Degree in Medicine; holder of a license to practice medicine in New Jersey or complete eligibility therefor.

AND

Satisfactory completion of two years full time working experience in a position requiring administrative responsibility for public health programs of a scope and nature acceptable to the State Department of Health for such experience.

OR

Satisfactory completion of one year full time planned working experience with the State Department of Health.

VII: Qualifications (continued)

(4) A baccalaureate degree, signifying the completion of a four-year undergraduate course, from a recognized college or university, including or supplemented by credit courses in public health or in the biologic or sanitary sciences.

AND

Satisfactory completion of two years full time working experience in a position requiring administrative responsibility for public health programs of a scope and nature acceptable to the State Department of Health for such experience.

OR

Satisfactory completion of three years of supervised full time working experience in public health programs of scope and nature acceptable to the State Department of Health for such experience and possession of a Sanitary Inspector First Grade license for a minimum period of three years.

The qualifications for Sanitary Inspector, First Grade, are the following:

Satisfactory completion of a two-year Associate Degree course in a recognized college or university or two years training in a recognized college or university with satisfactory completion of sixty credit hours. The collegiate training shall includes credits in the biological sciences and/or physical sciences.

AND

Successful completion of the course in Basic Environmental Sanitation conducted by Rutgers - The State University.

AND

Successful completion of a Field Training Course designated as such by the State Department of Health.

Equivalent training and/or experience may be accepted in lieu of completion of the Basic Environmental Sanitation Course and/or the Field Training Course. The academic qualification is a basic requirement and no substitution is to be accepted.

VIII: Acts and Standards of "General Administration" under the "Minimum Standards of Performance for Local Health Departments in New Jersey" as Effective April 1, 1961.

84. Act. 1: Administer a planned public health program.

Standards:

84.1 Determine and define public health problems and needs.

84.2 Plan activities designed to meet local health problems and needs.

84.3 Evaluate activities periodically to determine progress toward solution of defined problems and needs.

85. Act. 2: Establish and apply personnel policies.

Standards:

85.1 Employ necessary properly trained, full time personnel, who are licensed as may be required by law, to provide the recognized public health activities in accordance with the minimum standards of performance for these activities.

85.2 Formulate written personnel policies to include hours of work, salary, vacation and sick leave, compensation for injuries, malpractice and automobile liability insurance, pension and retirement. When personnel are employed under Civil Service, these policies shall be in accord with Civil Service law and regulations as a minimum.

86. Act. 3: Provide adequate physical facilities and equipment.

Standards:

86.1 Provide safe, sanitary, attractive, well lighted and heated quarters adequate in size to accommodate the offices, clinics, and laboratories operated by the health department. These shall be conveniently accessible to the public.

VIII: (continued)

86.2 Provide fire-resistant storage for vital registration records.

86.3 Provide office, field and laboratory equipment of a type and in quantity sufficient to enable personnel to do their work competently and efficiently.

86.4 Provide for necessary transportation for field personnel.

87. Act. 4: Establish efficient office practices and fiscal procedures.

Standards

87.1 Provide reception and telephone answering services during regular business hours; such hours to be announced to the public.

87.2 Maintain a filing system adequate to make correspondence and records of the department readily available to health department personnel.

87.3 Maintain an accounting system adequate to insure control of income, expenditures, supplies and equipment, and blank licenses, certificates and permit forms.

87.4 Provide for prompt issuance of licenses and certificates during all regular business hours.

87.5 Activities of health department personnel shall be reported and adequate records maintained in a specified manner upon forms provided for that purpose. Such records shall be retained in the files for a minimum period of two years and shall be kept longer when the legal or public health needs make this necessary.

88. Act. 5: Administer and enforce public health laws.

Standards

88.1 Administer applicable State law and the State Sanitary Code.

88.2 Recommend enactment of and administer health ordinances, codes, and regulations designed to meet current needs.

VIII: (continued)

89. Act. 6: Maintain a cooperative working relationship with other agencies.

Standards

89.1 Maintain liaison and cooperative working relationships with municipal, county, State and federal governmental agencies.

89.2 Establish a satisfactory relationship with the working press, providing them with information necessary for correct and informative material for publication.

89.3 Cooperate with local civil defense and disaster authorities in accordance with New Jersey Civil Defense and Disaster Control Plan.

IX: FUNCTIONAL ACTIVITIES -- ADMINISTRATION AND SUPPORTING SERVICES as mandated under "Certified Health Services" under the State Health Aid Act of 1966

GENERAL ADMINISTRATION

Certified Health Service

A. Establish the administrative apparatus to manage the activities of the local health agency.

Program Standards

1. Provide the services of a full-time, licensed Health Officer who will have administrative responsibility for all agency activities.

2. Develop and maintain a board advisory committee which may be the local board of health or a separate group of interested citizens.

3. Establish and apply planning techniques in order to:

   a. Determine and define public health problems and needs based upon analyses and interpretations of health statistics and other pertinent information.

   b. Establish program priorities based upon needs, resources and local demands.

   c. Develop pattern of activities to meet the current problems and needs in accordance with Personnel and Program Standards for Certified Health Services.

   d. Evaluate current programs periodically to determine progress, need for continuation or expansion.

4. Establish staffing and written personnel policies applicable to all persons employed by the health agency.

5. Conduct office practices and fiscal procedures which will:

   a. Provide for reception and telephone answering services during regular business hours.

   b. Provide for prompt issuance of licenses and permits during regular business hours.

IX: (continued)

c. Maintain a filing system to make correspondence and records readily available to health agency personnel.

d. Provide records and forms for reporting by health agency personnel. Standard inspection forms shall be based upon the requirements contained in the specific regulation covering each inspection activity.

e. Maintain an accounting system to ensure control of income and expenditures, supplies and equipment, and blank licenses, certificates and permit forms.

f. Institute record management practices in conformity with the records retention schedule for local health records as prepared by the Archives and History Bureau, New Jersey State Library, Department of Education.

6. Provide physical facilities and equipment to include:

a. Safe, sanitary, attractive, well-lighted and heated quarters adequate in size to accommodate the offices and clinics operated by the health agency.

b. Office and communication equipment of a type and quantity to enable personnel to function competently and efficiently.

c. Necessary transportation for field personnel.

VITAE

VITAE

Mark Anthony Quinones was born January 13, 1931, in New York City, New York. He attended elementary and high school in that city, graduating in January, 1949. During February of that year, he enrolled at Southeastern Louisiana University, and graduated in 1953 with a B.A. degree in Social Sciences.

Following graduation, he entered Louisiana State University as a Graduate Assistant in the Department of Sociology, graduating with a Master of Arts degree in 1955. That fall, he entered Wayne State University as a National Health Fellow where he completed the requirements for the Master of Health Administration degree in 1956.

From 1956-57 he was employed as a Health Educator, Tuberculosis League of Pittsburgh. From 1957-62 he was a field consultant for the New Jersey Tuberculosis and Health Association, during which time he attended the New School for Social Research as a part-time evening division student taking courses in sociology, anthropology and psychology.

From 1962-64 he was the Executive Director of the Passaic County (NJ) Heart Association, and from 1964-69 he served as the Director of the Northwest Area (NJ) Tuberculosis and Health Association.

His employment was interrupted in August, 1965 when the writer resumed his studies toward a Ph.D. degree in Sociology at Louisiana State University.

In the winter of 1969 the writer became Project Coordinator, Research and Development Department, College of Medicine and Dentistry of New Jersey/Newark. In 1970 he transferred to the Department of Public Health and Preventive Medicine, now the Department of Preventive Medicine and Community Health, initially as Administrator for the Division of Drug Abuse, and subsequently as Assistant to the Chairman and Director, Division of Social Medicine and Training, and a member of the faculty of the College. Recently he has also been appointed to the staff of the Dean of Medicine.

The writer has also served on the faculties of Rockland Community College, Suffern, New York, (1961-63) and the Sociology Department, Fairleigh Dickinson University, New Jersey (Madison Campus (1964-65, and Rutherford Campus as Visiting Assistant Professor, Summer 1971).

In January 1952 the writer married Marlene Phyllis Emerson of New Orleans. On August 20, 1953 their first daughter Roxane Marie, was born in New Orleans. She is currently a student at LSU. On December 19, 1958 a second daughter Karen Leigh was born in Orange, New Jersey.

EXAMINATION AND THESIS REPORT

Candidate: Mark Anthony Quinones

Major Field: Sociology

Title of Thesis: The Occupational Role of the Public Health Administrator in New Jersey

Approved:

George A. Tracy
Major Professor and Chairman

Max Goodrich
Dean of the Graduate School

EXAMINING COMMITTEE:

Quentin Jenkins

R. J. Farrell Cook

Jane De Grummond

Remander

Date of Examination:

November 29, 1971